UNITED STATES DISTRICT COURT
SOUTHERN DISTRICT OF FLORIDA
MIAMI DIVISION
Case 01-4319-CIV-KING

SYLVIA ALLEN,
Plaintiff,
vs.
R.J REYNOLDS TOBACCO COMPANY,
and PHILIP MORRIS INCORPORATED,
Defendants.

MIAMI, FLORIDA
FEBRUARY 24, 2003
MONDAY - 9:00 A.M.
MORNING SESSION

TRANSCRIPT OF JURY TRIAL PROCEEDINGS
BEFORE THE HONORABLE JAMES LAWRENCE KING,
UNITED STATES DISTRICT JUDGE
VOLUME 1A

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MORNING SESSION

THE COURT: Bring the jury in, please.

[The jury enters to the courtroom.]

THE COURT: Thank you. Be seated, please.

Mr. Reilly, would you like to call your next witness, please.

MR. REILLY: Yes, Your Honor. George Hensley.

COURTROOM DEPUTY: Would you state your full name, spelling your last name, please.

THE WITNESS: H-e-n-s-l-e-y, George, T.

GEORGE T. HENSLEY, DEFENDANT'S WITNESS, SWORN.

DIRECT EXAMINATION

BY MR. REILLY:

Q. Doctor, you might pull that microphone down just a little bit.

A. Is that better?

Q. Maybe you bent it. There ya go. It looks good.

Please tell the jury your name.

A. My name is George T. Hensley. I reside in Virginia. I am a retired physician.

Q. Could you tell them what your current profession is?

A. I am a pathologist at the University of Miami School of Medicine, retired since 1995.

Q. Could you tell this jury, do you continue to consult with the University of Miami School of Medicine, Department of

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Pathology?

A. Yes, I do. I am currently involved in search activities with the university.

Q. Can you describe for the jury what your current research activities are?

A. Since retirement, I published in two areas with people on the faculty. I wrote a paper on trauma surgery which was published in December. The other, a radiology paper based on studies done on AIDS patients to delineate improvement of diagnosis by means of x-ray imaging.

Q. Doctor, can you tell the jury what kind of consulting work you do?

A. In addition to the research activities, I consult with faculty members in the department who occasionally send me onset cases to get my opinion on. I do that as well for other physicians practicing also here in South Florida, many of whom were my students trained at Jackson Memorial Hospital and who settled in this area to practice.

Q. Doctor, how long were you a professor of pathology at the University of Miami School of Medicine?

A. Twenty years.

Q. Tell me when you began being a professor here.

A. 1975.

Q. Tell me if you were a tenured professor.

A. I was a tenured professor at the medical college in

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Wisconsin and when I came to Miami, as is customary, in the department, when I first joined as professor, I surrendered my tenure and resubmitted my credentials to the American Tender Committee at the University of Miami. They were approved, and I was tenured here I think the same year that I joined the faculty.
Q. Where did you receive your undergraduate degree?
A. I went to undergraduate school at the University of Toledo, which is in Ohio. I got a bachelor's degree there majoring in chemistry and zoology. Subsequently, I went to the Ohio State University School of Medicine and graduated from there in 1957. Following that I took postgraduate training.
Q. An internship?
A. Yes, I took an internship from 1957 to '58. Subsequently, I did my training in pathology.
Q. Is that a residency program?
A. It is.
Q. How long is your residency program?
A. It was four years.
Q. What was your residency program in? What type of pathology?
A. I was actually trained in anatomic pathology and clinical pathology. But at the time, I would say, when I was a fourth year resident, I decided that I would make my career in anatomic pathology, so I sat for the boards in anatomic

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pathology and skipped the certification in clinical pathology because I knew I did not want to do that kind of work.
Q. Doctor, could you tell the jury, what is anatomical pathology.
A. There are two broad categories in pathology. One is anatomical and one is clinical. We anatomic pathologists are diagnosticians, basically. We look at organs and tissues that are examined by means of biopsy or organs and tissues that are removed completely from diseased patients. We assess the organs and tissues initially, and then we prepare materials that we can examine under the microscope. We eventually make what we call an anatomical diagnosis, what is actually wrong with those organs and tissues. We report that information to the surgeons or internists or whoever is concerned for their consideration in diagnosing and managing the patient as a whole.
Clinical pathology, on the other hand, you can think of pathologists who work in the laboratory with test tubes and automated machinery for analyzing fluids. They devote their time to looking at blood and urine and cerebral spinal fluid and that sort of thing. I am not concerned with that.
Q. Doctor, included within the framework of pathology, is immunohistochemical staining included?
A. Yes, they are important areas, and I have been using them for years, particularly in the diagnoses of diseases of the

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kidney. I have been involved in the involvement originally with the immunohistochemical laboratory in the medical college in Wisconsin where we used it to diagnose a kidney disease, principally.
Here in Miami it has a broader range of the applications, and so the technology is the same as what I instituted and, of course, there are no developments.
Q. Bless you.
Doctor, could you tell this jury whether or not you are what they call board certified?
A. Yes. I took the board examinations in 1963 in anatomic

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pathology and, of course, I passed them and I am board certified.
Q. Tell this jury what your responsibilities were as a professor at the University of Miami School of Medicine.
A. Yes, I had basically two roles. One as a professor with the university and the other as attending pathologist caring for patients at Jackson Memorial Hospital, which is a teaching hospital. Sometimes those roles merged, in fact, most of the time.
Let me commence by saying generally as a faculty member of the University of Miami, I had three areas in which to work. First, I was a teacher, and secondly, a researcher, and thirdly, I was a diagnostician working with patients hospitalized at Jackson and its affiliated hospitals, including

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the Veterans Administration Hospital and the Eye Institute, et cetera.
There is a combination there because in the training of resident pathologists at Jackson Memorial Hospital was sponsored not by the University of Miami but rather by the Public Health Trust of Dade County. So much of my teaching effort at that time was devoted to teaching these people on a postgraduate level and preparing them to take the boards and become practicing pathologists.
The division at my time was three areas, probably the twenty years that I was there was probably about one-third, one-third, one-third.
Q. Would you like some water, doctor?
A. Thank you.
Q. Doctor, tell the jury whether or not -- you indicated just a moment ago that you have done research. Have you published in peer-review scientific journals in the area of pathology?
A. Yes, the only publications that I put in my CV are those that are published in peer-review journals.
Q. Do you have seventy-five or more?
A. Around seventy-five. Frankly, not everything made it to the journal. Sometimes they slipped through the cracks. And I am not very compulsive about keeping long lists. I think there are seventy-three or seventy-four up to December, 2002.
Q. Doctor, could you tell the jury whether or not you have

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been the author or co-author of any book chapters on pathology?
A. Yes, I did write a chapter on biopsy diagnosis of small bowel disease and a textbook on gastroenterology.
Q. Doctor, have you written on the subject of the pathology of kidneys and/or lungs?
A. I have a substantial number of publications on the pathology of lungs, because when I was at the medical school in Wisconsin, our department, together with the department of internal medicine and immunology, were the recipients of the NIH, National Institutes of Health, grant and looking into the causes and the diagnosis and treatment of what was known as hypersensitivity pneumonitis. So I saw a great number of patients whose lung biopsies I looked at. Of course, a number of biopsies during those years and a number of publications came out of that.
I have been involved in pathology of the kidney since those days too. At the University of Wisconsin, I instituted the renal biopsy assessment by immunohistochemical means. I also did a submolecular microscopy of the kidney.
Q. That's using an electronic microscope?
A. Yes. Subsequently, at the University of Miami I have functioned in kidney pathology and extended the range of my

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responsibilities there to the transplant program. I was at the University of Miami, the pathologist who initiated the service for evaluating biopsies who transplanted hearts, livers and

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kidneys.

I want to back up and correct one of the things I just said. I was intimately involved in the initiation of the transplant service at Jackson. Another of my colleagues, Doctor Victor Pardo, played a very important leading role with respect to the kidney, but not in the case of the heart and liver.

Q. Tell the jury what level of medical students you taught as a professor at the University of Miami School of Medicine.

A. In Miami, as opposed to Wisconsin, a great majority of my teaching was done at the postgraduate level.

Q. The jury probably already knows, but just for refresher sake, what does postgraduate mean in the world of medicine?

A. For example, our department, at Jackson and U.M., puts on a course every February that teaches pathologists and other interested doctors what is the latest happening in our field. It's attended by doctors from all over the country.

Of course, most of them are from the Southeast, but some even come from Europe and Latin America. So I participated in that program.

I was also appointed to the Rosenstiel Institute of Marine and Atmospheric Scientists to teach and to advise Ph.D candidates and marine biologists who were working in areas involving the pathology of animals in the sea.

But the bulk of my postgraduate teaching was for the

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benefit of young women and men studying pathology and attempting to become specialists in it. That I did on a daily basis for many, many years.

Actually, if you consider my work in Wisconsin, it's well over thirty years.

Q. Doctor, included among your students, those would have been the residents and fellows at University of Miami, Jackson Memorial?

A. Yes.

Q. At Wisconsin were you focused more on medical students rather than the people that were in their postgraduate work?

A. I did both, but I did spend substantially more time lecturing to second-year medical students and I advised students beyond that level on various research projects that were undertaken by those few who were interested in pursuing medical science as a career.

Q. Doctor, tell the jury whether or not among your students was a Doctor Nadji.

A. Yes, Doctor Nadji was a resident pathologist when I joined the faculty in 1975. He actually was a senior status at that point. His first two-and-a-half years I think had been completed before I arrived. Subsequently, of course, Doctor Nadji joined the faculty. We were very pleased to recruit him. I worked with him until 1995. I worked with him for more than twenty years.

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Q. Doctor, the State of Florida enjoys a population of pathologists working in various hospitals around the state. Can you give this jury some sense of what percentage of those pathologists you trained?

A. Well, I'm not sure I can make an estimate of the percentage. I can only say that it is a very large number. There is a hospital in southeast Florida, north of here, that

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doesn't have somebody who was trained at Jackson Memorial partly under my direction. Many cities in the state, including the west coast and some in the north. But in addition, of course, I have students all over the world now.
Q. Doctor, tell the jury, while you were professor of pathology at the University of Miami, you also held administrative responsibilities at the medical school and Jackson Memorial.
A. Yes, sir, from time to time, I held various administrative responsibilities.
Q. Tell the jury what those were.
A. Well, initially and occasionally in later years, I was director of the autopsy service as well as an attending pathologist in the surgical pathology service. At that time I was responsible for pulmonary pathology.
Q. Pulmonary meaning lung?
A. Lung.
I and others in our department worked hard to recruit

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a pulmonary pathologist to take over that area and we finally succeeded. But in the beginning years I had to do it because I had experience from Wisconsin.
When the director of anatomic pathology left, I had to move into that position administratively. The director of anatomical pathology is the person who directs all of the anatomical pathology activities. That includes surgical pathology; all the subspecialties, like skin, lung, kidney, transplants, the like, and cytotoxicology. I functioned in a service capacity in surgical pathology as well as directing all of the anatomical activities.
Later, particularly after the outbreak of the Acquired Immunodeficiency Syndrome --
Q. AIDS?
A. AIDS. It was necessary for me to become rather deeply involved in research in that area and I spent a lot of time in it, and I diminished my administrative duties, so toward the end, I had hardly any time for that.
Q. Doctor, was the immunohistochemical staining and histochemical staining under the anatomical pathology services?
A. Yes.
Q. Doctor, you mentioned that you were director of autopsy for a significant period of time at the University of Miami. Can you explain to the jury what that means?
A. Autopsies are a very important part of hospital pathology.

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They are very important for teaching surgeons and internists and other medical specialists, when we had the opportunity to look at the complete picture of a patient from the time he came in until the time he, unfortunately, passed away.
As director of autopsy pathology at Jackson, I supervised autopsies done by resident pathologists. Occasionally, I would do them with my own hands, but obviously, I didn't have a lot of time to do very many at that point. I also consulted with Doctor Clark at the Veterans Administration Hospital, which is part of our teaching complex at Jackson.
I participated in the autopsy services of the medical examiner's office in Dade and Broward County. They had a enormous number of autopsies to do. Although their basic mission is to look into deaths or accidents, suicide or that sort of thing, inevitably when they do a large number of persons they have persons with complicated medical disease, either known about or more often than not, not known about. So I would consult with those examiners to evaluate those complex

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cases.
Q. Doctor, could you give the jury a sense -- I realize you don't have an exact number, but can you give them a sense of how many human autopsies you have done in your career?
A. Thousands is the best I can do. The total number of autopsies I have supervised and participated in with medical examiners and at the various hospitals locally, and in fact,

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around the country, probably over ten thousand or more.
Q. Doctor, would you like to take a drink?
A. No, that's all right.
Q. Tell the jury if you have taught at other medical schools as a visiting professor.
A. Yes, I was the visiting professor at the Autonomous University in Mexico City, and I was the visiting professor at the University of Haiti in Port-au-Prince. In that capacity I was assisting the folks down there chiefly in diagnosing the acquired -- AIDS. Also, I might add teaching them histochemical methodology that was necessary to make the diagnosis of a disease. They had not had any need to use those more advanced, sophisticated methods before AIDS came up. They were doing very well. We went down and helped beef up their laboratory diagnostic facilities.
Q. Doctor, could you tell the jury whether or not you have had your research funded by such organizations as the National Institute of Health?
A. Yes, I have. I have already mentioned the grant in Wisconsin, which is a very major grant, involving not just myself but youth marketing technology and medicine. Also we have had a grant here in Miami to look at the pathology of heart in the acquired immunodeficiency syndrome.
Q. You are still licensed to practice medicine here in Florida?

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A. I am. I'm inactive status, but I am required to meet the continuing medical education criteria mandated by the Board of Medical Examiners, and on my desk at home is a set of exams that I have to complete when I get back.
Q. You anticipated my next question. Do you remain current in the state of art in the area of pathology?
A. Yes, I spend a great deal of time on that subject.
Q. Doctor, have you testified in court before?
A. Yes, sir, I have.
Q. Could you give the jury a sense of if you were involved as a consultant to the coroner's office for both Miami-Dade County and Broward County, were you called upon to --
A. Autopsy, I consulted on, not the autopsies that I performed with my own hands. Yes, I testified in Broward and Dade County in criminal cases involving homicides.
Q. Doctor, have you testified in cigarette litigation in the past?
A. Yes, sir, I have.
Q. On how many occasions?
A. Four or five.
Q. Doctor, do you charge for your consulting services in legal matters like this?
A. Yes, sir, I do.
Q. What is your hourly rate?
A. For testifying here in court today?

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Q. Yes, sir.
A. My hourly rate will be five hundred dollars.
MR. REILLY: Your Honor, I would tender Doctor Hensley

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as an expert in pathology, anatomical pathology, including the subparts of histochemical staining and immunohistochemical.

THE COURT: Do you have some voir dire?

MR. GROSSMAN: Yes, sir.

THE COURT: All right. Voir dire.

VOIR DIRE EXAMINATION

BY MR. GROSSMAN:

Q. Doctor Hensley, good morning. I am Stuart Grossman. Doctor Hensley, you testified that you testified in four to five cigarette cases; is that true?

A. I believe it is. I never made meticulous notes. I believe I jotted it down in my CV. I believe it was four or five or six including today.

Q. And you have also given depositions in these cigarette cases as well?

A. Oh, yes, substantially more.

Q. Have you ever testified, ever testified, in a cigarette case on behalf of the person who lost his or her life or has it always been for the tobacco manufacturers?

MR. REILLY: Your Honor, I object.

THE COURT: I think at this time we are dealing with whether or not he should be an expert. It would go to his --

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he has been telling us now, for about twenty minutes, thirty minutes his background. If it goes into that, that's fine. Other things I think would be cross-examination.

BY MR. GROSSMAN:

Q. Doctor Hensley, you said you retired in 1995; is that correct?

A. Yes, sir.

Q. Now, if you wanted to practice medicine today in Florida, could you today?

A. Well, I would have to apply to have my license reactivated, yes.

Q. You would have to apply to have it reactivated?

A. Yes, of course. I would request of the board of medical examiners that my active status be reinstated.

Q. In this particular case you did your work, I take it, in the state of Virginia?

A. Yes.

Q. Are you licensed in the state of Virginia?

MR. REILLY: Your Honor, again, I don't think this goes to his qualifications.

THE COURT: As to where he is licensed, that would be proper. Go ahead, what else?

BY MR. GROSSMAN:

Q. May I ask you if -- since your retirement in 1995 and specifically in this case, you were asked if you had been

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consulted by the university. I am not quite sure I know what that means. Did any of your colleagues at the University of Miami ask you to look at the Allen case?

A. No.

Q. That would include Doctor Civantos?

A. Yes, that would include him. I have not talked to Doctor Civantos for some time.

Q. Doctor Nadji, did he ask you to consult in this case?

A. No.

Q. You said that immunohistochemical staining is something that you have been using for quite some time, even beginning at the University of Wisconsin, correct?

A. No, I said the medical school in Wisconsin.

Q. Forgive me.

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A. Yes, it's called the medical college of Wisconsin.
Q. So you have been familiar with that type of staining now for years?
A. Yes.
Q. And mucicarmine carcinoma staining, is that something that you did here in the university?
A. I was first required to perform mucicarmine carcinoma staining when I took a course in probably 1951. So I have been personally familiar with it since that time.
Furthermore, I have been responsible for evaluating the properties of mucicarmine carcinoma stains in the schools

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of histo technology both in Wisconsin and here until my retirement.
Q. I believe that I highlighted on our little computer that we have from the court reporter is words to the effect of immunohistochemical studies are things that you would use routinely in making diagnosis of renal or kidney cancer, correct?
A. No. I didn't say that.
Q. Do you use immunohistochemical studies in diagnosing kidney tumors?
A. They are used and they are useful, but the greatest application in immunohistochemistry and renal pathology is for inflammatory diseases of the kidney, not cancer.
Q. Not cancer. For cancer of the lung, do you recognize mucicarmine studies as being significant?
A. Well, in a particular context, it's not a routine stain.
Q. I didn't say it's a routine stain. Do you think it's of value in making a lung cancer diagnosis?
A. Yes, in some cases.
Q. Finally, did you have the pathology slides and blocks made available to you in this case?
A. I have the pathology slides, yes; the blocks, no.
Q. Did you ask for the blocks?
A. No.
Q. You never requested them?

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A. No, sir.
Q. Did you do any mucicarmine staining in this case yourself?
A. No.
MR. GROSSMAN: Your Honor, if we could have a moment of your time outside the presence of the jury.
THE COURT: All right. Ladies and gentlemen.
[The jury leaves the courtroom.]
THE COURT: Doctor, would you please wait outside.
THE WITNESS: Yes, sir.
[Witness is excused.]
MR. GROSSMAN: Your Honor, the last two questions dealt with the mucicarmine staining, which, of course, is the way that the particular staining that you have heard about in this case, that diagnoses lung cancer. There has only been one pathologist that did that staining, although the slides were certainly available to Doctor Hensley, he had them. We can show you on three separate occasions, maybe four, defense counsel obtained blocks. Let me tell you about that, if I might.
Tissue taken from the body. It's frozen. Sometimes, other times it's put in paraffin and blocks are made. Those blocks are then cut by a very thin knife called a micronome. The doctor from Washington -- I'm sorry, Doctor Sam Hammar came from Washington to testify about that.
THE COURT: Yes, you explained about the blocks a

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couple weeks ago. I can remember it that long. A month from now I won't know. I remember what you are saying about the paraffins. Anybody has the accessibility to them now.

Let me jump ahead. Has this doctor been tendered in the staining process that you are talking about?

MR. REILLY: Yes, Your Honor.

THE COURT: Has he been?

MR. REILLY: Yes, Your Honor. I had him go through his experience with immunohistochemical --

THE COURT: So you are tendering him in his background as a pathologist and in the staining of the samples and that sort of thing? The whole thing?

MR. REILLY: Sure. Sure.

THE COURT: Excuse me. I did not understand that Mr. Grossman, go ahead.

MR. GROSSMAN: Judge, they spent some time on that.

Now, what is about to happen -- of course, we know this because we took Doctor Hensley's deposition -- that he is not going to come in -- and we now know this -- and say I took the blocks, I cut some fresh tissue and I did staining. He will not say he did that, although he is qualified to do that and he has done it for nearly thirty years.

What he is going to say is that he is critical of Doctor Hammar and the way Doctor Hammar did this in two ways.

One, he is going to tell the Court and the jury that

the slides that Doctor Hammar had up on the screen were out of focus, they were not focused.

Secondly, --

THE COURT: You mean when it was here in Court?

MR. GROSSMAN: Yes.

THE COURT: He can't say that because he wasn't here. He can't get into commenting upon somebody else's testimony. I doubt that counsel is going to try to get into anything like that. He may ask this doctor if he is otherwise qualified, and he appears to be. He may ask him questions about how one does staining or how he does staining or something like that and then argue to the jury later on, or attempt to show it, that Doctor Hammar's staining was some how deficient or whatever he may wish to argue around those lines.

Nor has there been in this trial. I have tried to keep this out of it, where people come in and say, "Well, I read the testimony of Mrs. Jones or Doctor Smith and all of that." It's not commenting on each other's testimony. That leads only to bring back the other doctors and say, "Well, I disagree with him," and so on and so on.

I don't think that Mr. Reilly is probably going to attempt to do that. Although I will hear from him. If I am anticipating incorrectly on that, well, I will find out.

But the question here now would be, it is at this point, whether or not this man with his background is a

qualified pathologist and qualified in the field and knowing about staining and taking these tests and doing these things. If you are anticipating that he is just going to sit here and knock Doctor Hammar, well, I am sorry. Here we go with all of these anticipatory rulings. All you have to do is make your proper objection at the time if you have one. Then I will rule on it.

MR. GROSSMAN: Thank you. I have now alerted the Court, because I know that he didn't do his own staining. He is going to comment on the quality of staining that is done

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which is a knock on Doctor Hammar and something that is not permitted. That's reason number one.

Number two, Judge -- and now I get into the heart of this matter even further -- you need to think about this, please. The expert had the ability, the talent, the knowledge to do his own staining and chose not to in this case. I believe if you allow me to ask him a question as to whether or not that's what he would have routinely done in his practice, if you wanted to know was this lung cancer or was this a kidney cancer, kidney tumor, lung tumor, he would have said, "Had I been consulted, I would have stained it. Anybody would have stained it."

Under Daubert and the cases that follow it, because he is going to come forward and say what he is doing in court is not being as careful as what he would have done in his regular

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professional work, outside of his paid regular work of consulting, comes into one of the holdings in Daubert and one of the holdings in Braun v. Lorillard, a tobacco case. This is very important.

On Saturday morning I was delivered to the hotel I am staying at a photograph with a cover letter from the Shook, Hardy firm. It says, "Please be advised that defendants will be calling George Hensley, M.D. today. We will be using, with Doctor Hensley, one controlled slide, a copy of which is enclosed, then the rest is all Hammar material."

In fact, they asked us to have all Hammar's materials available. It's not anticipatory. I have been told in a letter what they were going to do.

THE COURT: All of this anticipatory ruling stuff, you know, I am losing patience with it. I am sorry.

Here is what this amounts to. We are not going to let anybody come in here and say Doctor Hammar is a bad guy. He has had three divorces and he is a drunkard. We don't do that. We don't let him come in here and testify, if that is what you are concerned about. And, "Well, I have known Hammar and he is not as well thought as somebody that does staining pathology or whatever."

What he can do, I presume, is be handed a slide and say, "Will you look at this and what do you see on it." He can tell the jury what he sees on it. Then he can be asked what is

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the procedure for making slides, and he can tell that. The line is crossed when somebody says, "Another doctor said that he saw this and it was brain cancer. What do you think about that." Whoops, at that point, we cut it off.

I don't know what you have been doing in other trials in state court or all over the country. This doctor can talk about what he does and what he sees on the slide. Then you can bring out, you can bring out on cross-examination, certainly, that if he would have wanted to, he could have taken his own slides. That's cross-examination. That goes to the weight to be given to his testimony. But that's cross-examination.

At this point, we are only at the point of whether this man of twenty years' experience, as a medical professor in medical school, with his extensive background, is qualified to express opinion-type evidence. It seems to me he is. I didn't see any flaw in his background that would eliminate him from that.

You know, you-all take depositions all over the place and you ask all kinds of questions at depositions. Half of it can't be brought out in court. Not in this district anyway. Judge Higgenbotham said you and I date ourselves to the

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approach to the ethical, expert witness situation where the lawyers are supposed to argue the case, not the witnesses. He laughed. I said, "I guess we do." He and I both feel that way. He sees what happens in other courts and I don't, unless

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I sit on the Appellate Court occasionally. He sees it all the time. He says it's absolutely ludicrous what lawyers are bringing into cases these days. The approach is throw the door open and dump out the garbage all over the floor and let the court or jury sort it out. I am digressing. That's just not the way it is tried here.

If some of that has slipped in here, it's because there weren't objections made that I could rule on and I didn't catch it until it was in. So I have tried to keep it on the basis that the expert comes in and testifies as to what he knows, what he sees, and the slides that he took. And then he says, "No." Or maybe, "No, I am so expert that I can tell by just glancing at a slide." Then the jury can believe him or not.

Mr. Reilly will show that he is a expert and he can just glance at this thing and know in a heartbeat what his students take four weeks to learn.

Here, I will inquire, since we have gone so deeply into it, if there's any confusion in anybody's mind about drawing parameters on commenting witnesses as to whether or not that is a problem for anybody, and let me give Mr. Reilly an opportunity to respond to that. Apparently Mr. Grossman didn't quite. Excuse me. I will give you an opportunity, Mr. Reilly, to comment on that.

Mr. Grossman.

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MR. GROSSMAN: Your point on one expert commenting is well made and well-known throughout this trial. I am moving off of that. You need to please decide whether or not if you asked the following questions, "Doctor, if you were at the University of Miami, and this patient had come to you in normal channels, would you have stained his specimens in order to see if it was lung cancer or kidney cancer." If he answers affirmatively, then what he is doing is behaving differently as a paid litigation consultant.

I am reading from Daubert and from a case that followed this specifically called Sheman v. Daily Racing Forum out of the 7th Circuit. Let me give you this one sentence. Sheman says -- I have a copy for you. What happened was some people were fired at the daily racing forum. They wanted to see if there was age discrimination. An expert came in and said, "I will tell you who is allowed to stay." But he selected out certain people that were older. The mean age of those who were allowed to stay and work dropped in.

Indeed the analysis was not admissible under the standard of Daubert v. Merrill, Dow Pharmaceuticals Inc. giving the Supreme Court citation, "governing the admissibility of expert testimony which requires the district judge to satisfy himself that the expert is being as careful as he would in his regular professional work outside his paid litigation consulting."

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Then they cite Braun v. Lorillard, Rosen v. C. Bagatti. Come back and cite Daubert again. A case called Mid Fertilizer Company, in other words, loaded with penny authority as to the gatekeeping job.

Judge, respectfully, he didn't do his work when he could have done his work, the same work he would have done if

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this was an honest inquiry as to what Mr. Allen had.
If you determine that he did not do the same type of work on Mr. Allen's case that he would have done if he were sent these slides by Civantos and Nadji or the men that he trained to work with, I honestly believe, I honestly believe, that there is a requirement that you wouldn't be satisfied as to his testimony.
I know -- I know we take depositions all over the place, but we have given up these blocks -- I will finish by saying what I said -- on three different occasions someone has tested them. The witness being called today hasn't tested them? Why is that? Why wouldn't it be that he would have tested it. This is what Judge Higgenbotham would tell you. "This is the problem with experts. This is exactly the problem of a selective use." Maybe he won't now comment on Doctor Hammar. That's what he did in his deposition when we asked him his opinion. Maybe he won't now. But the bottom line is he didn't do what he could have done and should have done which would have been exactly what he would have done in practice,

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which is, "I'll stain myself. I have been doing it for thirty years."
THE COURT: Would you give copies of the cases that you cited to the marshal.
MR. GROSSMAN: Yes.
MR. REILLY: Judge, I don't know how much argument is necessary here.
THE COURT: Take your time.
MR. REILLY: The issue here is whether or not Doctor Hensley is qualified to give opinions regarding pathology. I have qualified this man who has been a full professor at the University of Miami School of Medicine for more than twenty years.
THE COURT: I understand that, and I will let you come back to that.
MR. REILLY: I will address the next question now, Your Honor.
Doctor Hensley reviewed all the slides produced by Doctor Civantos, all the slides prepared by Doctor Nadji, all the slides prepared by Doctor Hammar. He is prepared to come and testify about what he sees in all of those slides, period. That's what pathologists do. That's what he is prepared to come to do today.
In the deposition taken by Mr. Yaffa of Doctor Hensley, he was asked whether or not he thought the pictures

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were in focus. I don't know whether he volunteered that he thought the pictures were out of focus. Not the slides.
There's a difference between the glass slide that all of these specimens are put on and whether or not the guy that takes a picture with a camera is -- whether or not the picture is in focus. I don't care if the picture is in focus. Do I intend to ask him that? I couldn't care less. All I care about is is the picture of good enough quality so that he can look at it and say yes, I can see whether there is a positive or negative mucicarmine stain here, which he can do. And that's what he is going to come tell this jury.
As to whether or not he prepared stains himself, you will hear from this witness each step along the way whether or not he will do this or that or something else. I don't know for sure, but we will have to hear it from him, whether or not he would have gone further and done a mucicarmine stain on this tissue at all.

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That isn't whether you are qualified to give testimony as an expert in the case. That relates to the issues of the case, not your qualifications.

In fact, I don't think I could have brought a more eminently qualified expert than someone who has taught roughly a hundred or two hundred of the active pathologists working in this state today, in this state who taught Doctor Nadji, who rubbed shoulder to shoulder with Doctor Civantos. How could I

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have brought a more qualified expert to Your Honor, to these people, to this Court?

THE COURT: I don't have any difficulty with that. It's almost a given. The man is a very highly qualified person. The issue that is -- is presented that if an expert witness is hired by one side or the other -- this is my phraseology of the issue as I understand it. I have not looked at the specific reference in the case that Mr. Grossman referred to, which we will do or we will have the chance to do.

The specific issue as I understand is raised that when an expert is called, is hired by either side, that that expert then has an obligation to do a full, my word, a full examination or preparation, in this instance, staining slides, for example. If he does not do that, then his testimony, according to the argument, is subject to being excluded because by omission or elimination of certain tests, his opinion then is suspect so as to be precluded under Daubert, as I heard the argument. That is the legal argument that he is making.

That's a little bit different twist on Daubert than I have had occasion to think about in my felony voting cases and other cases that were not medical malpractice cases. So it's a little bit different approach, a little bit different twist, and it's a suggestion that an especially consulted or hired expert to bring in to trial to testify, if he has not done certain tests or certain examinations, then, by omission, or

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leaving it out on purpose, it can get a secured result in his opinion. Something like that, I think, so please tell me.

MR. REILLY: Your Honor, let me address the ludicrousness of that argument. That would mean that in any malpractice case involving pathology, that the pathologist expert who was brought into the case to testify would have to not be able to use the pathology who was generated during the course of the care and treatment of the patient. Instead, he would have to go out and do his own pathology. That's ludicrous. It doesn't happen in medical malpractice cases.

Frankly, I was surprised that Doctor Hammar, without any -- I'm sure I could have objected to this. Because Doctor Hammar, without any consultation with anybody, took the paraffin blocks in this case, and without any authority from Your Honor or anybody else, performed tests on those blocks, took these slices, did tests, totally unbeknownst to anybody. Did I complain about it? Heck, no. I don't care if he does it. But am I obligated, is my expert obligated to do that? Absolutely not. There is not a case on this planet that says he is. Not one. That's the argument that they are making.

I will say this. Doctor Hammar's work, his slides, were made available to Doctor Hensley for his view, along with the pathology slides prepared at Jackson Memorial Hospital. He reviewed them both. You reviewed them both. Unfortunately, Doctor Hammar did not include the control slide for the

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mucicarmine stain. We don't have -- and you heard me ask him about it. He didn't bring it to the deposition, or he didn't

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bring it to this slide -- we don't have what a positive mucicarmine stain would look like here as a control.

What we had Doctor Hensley do is bring an example of a positive mucicarmine stain control. That is the sum total of what Doctor Hensley has brought here. Everything else are the stains prepared.

Quite honestly, I didn't plan on showing very many stains to the jury because I think that it goes over everybody's head, but I did bring the staining of Doctor Hammar to show whether they are positive or not. I would use Doctor Hammar's if he brought it. But he didn't bring it so I can't use it.

If they want to cross-examine Doctor Hensley, "Did you do your own mucicarmine staining," they are free to do that. Ask away.

I am sorry.

THE COURT: That's all right. I wanted your analysis of the specific problem, and then I didn't want to interrupt all the rest of it. I don't have much difficulty in his qualifications as an expert. If I did cut you off or if there's anything you wanted to say, go ahead.

MR. REILLY: No, Your Honor, I believe I have covered the subject.

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THE COURT: Anything in rebuttal?

MR. GROSSMAN: Yes, Judge, the case -- it's been called ludicrous. It's not ludicrous. The case that I gave the Court is the law. It's anything but ludicrous. It's very serious business. Mr. Reilly has more or less put another log on the fire, knowing now that this witness has not even, here at court today, performed these very traditional studies, studies that I know he would have done day in and day out if he was looking for what is wrong with Mr. Allen.

This is a control picture. It isn't even from Bob Allen's body. This photo delivered to me, which I told you came on Saturday, has nothing to do with this case. It's a controlled study from someone's body or someone's tissue. It can't possibly be relevant in this case. This, of course, is the problem.

It's fascinating now that they have a control study -- and I will explain the controlled study in a moment -- that they would like to show whether someone has been doing some staining. How about doing it on the issue, or on the tissue that is the subject of this lawsuit, rather than someone else doesn't say this is what a controlled slide looks like.

THE COURT: This is another objection.

MR. GROSSMAN: Well, it's part of Daubert. It's not appropriate to say, "Here is what it should look like." I think that you would find out if it hasn't been made clear,

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that each particular case rises and falls on its own staining. We did not have this until it was delivered on Sunday. I don't even know where it came from.

MR. REILLY: May I respond, Your Honor, if it's necessary?

THE COURT: Well, this is on the second objection. My terminology may not be correct, but it's the second objection to the showing of what an example of a staining looks like.

MR. REILLY: Your Honor, a controlled slide never comes from the body of the patient. That is never done. You'll learn about it. This is all being done and presented to you in a vacuum. The controlled slide is specifically taken from a known entity.

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THE COURT: I understand. Thank you.
Let me read this case. The Sheman v. Daily Racing Forum. It's on summary judgment, as so many of these cases are.
I would pause parenthetically to say having spent a few hours over the weekend, not many, but a few, reading a number of cases that you all have submitted to me with reference to the Rule 50 motion for directed verdict. A very, very substantial number of all of those cases are decided on these preliminary motions and summary judgments and judgments on pleadings.
Knowing what I now know about these types of cases

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from having listened to witnesses and actually seen a trial and having the benefit by being educated by you lawyers on these issues, it seems to me that an awful lot of this cannot be resolved in summary fashion. That's just a personal observation. Whatever the law is, of course, we will follow it.
It seems to me that this summary judgment rush to determining pretty weighty issues that are factually based in that fashion may not be the best way to proceed. Let me take a look at this case. I am referring to the Sheman v. Daily Racing Forum case, which is 104 F.3d 940. This is a review of the Northern District of Illinois decision of summary judgment. Judge Posner, Chief Judge of the 7th Circuit, and well-known for his publications and opinions on these issues involving class actions and expert witnesses has been the author of this opinion.
It's interesting that I made the remarks that I made to you regarding the motions that you have made to me since this case is an excellent example of where appellate courts get off to writing and -- their opinions based on their submission on summary judgment or any pleading-type motions when really they are deciding on how the facts turn and could decide the issue.
Here, for example, it says in dealing with this -- this man had furnished an affidavit for the plaintiff in

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attempting to defeat the company's, the employer's, contention that they had nondiscriminatory reasons for the age discrimination or the firing of the man or the reduction in salary or whatever it was. So he files an affidavit.
In the affidavit he analyzes seventeen employees who had been laid off or had been disciplined, and in his affidavit he rejects two as not being relevant. Then he goes on. He files this affidavit. The Court considers it on summary judgment with no ability to cross-examine the man or anything else. The Appellate Court says, well, we are going to reject that affidavit under Daubert because -- and the language is here as Mr. Grossman quoted it: Daubert requires the district judge to satisfy himself that the expert is being as careful as he would be in his regular professional work outside his paid litigation, unquote.
Then we see what Judge Posner was getting at, what I mentioned earlier today, about how these things are fact determinative in many instances.
Quote, Although the expert used standard, statistical methods for determining whether there was a significant correlation between age and retention for the seventeen persons on the list, citing authority, the omission of Sebring and Shulman from the sample tested was arbitrary. The experts should at least have indicated the sensitivity of his analysis

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to those omissions. More important is the expert's failure to
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correct for any potential explanatory variables other than age, unquote.
On cross-examination he had been asked about all of that, of course.
Quote, Completely ignored was the more than remote possibility that age was correlated with a legitimate job-related qualification, such as familiarity with computers. Everyone knows that younger people are more comfortable with computers than older, et cetera, et cetera.
Quote, The expert could easily have inquired about the feasibility of ascertaining through discovery the history of the use of computers by each of the employees on the list of seventeen.
Quote, The expert's failure to make any adjustment for variables bearing on the decision whether to discharge or retain a person on the list other than age -- he's equating a simple statistical correlation to a casual relation -- indicates a failure to exercise the degree of care that a statistician would use in his scientific work, outside the context of litigation.
"In litigation an expert may consider, paren, he may have a financial incentive to consider, paren, looser standards to apply. Since the expert's statistical study would not have been admissible at trial, it was entitled to zero weight in considering whether to grant or deny summary judgment."
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All right, here we are. Before us is Doctor Hensley, who has been called for the purpose of giving his analysis of certain slides or x-rays, whatever they are, but his examination, his opinion of these things that other doctors have taken during the course of treating Mr. Allen. None of these people, apparently, that treated Mr. Allen took slides. Excuse me. They took slides. They did not do staining. They apparently did not feel professionally that it was necessary to do staining, to ascertain the location of the carcinoma.
Whether that was an omission on their part is another matter that may or may not be relevant to this trial. In any event, these matters can all be developed and go to the weight to be given to his testimony. Whether doctors and treating patients should do this staining technique or not, it seems to be an issue in this case or may be an issue in this case. But I think the man is qualified as an expert in his field as tendered.
The objection is overruled. I think that given the general parameters that we have established for all experts, or tried to in this trial, at least, where they are not to come in here just to knock on the other experts' testimony or comment on the other experts' testimony -- and this is another anticipatory ruling. I have made in this trial more than any other thirty years that I have been on the bench. I don't like to make anticipatory because I don't know how they are going to
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come up -- but I think it would be, generally speaking, inappropriate to come up for someone to inquire about this other witness, "Well, now, if you assume that Doctor So-and-so said that and Doctor Jones said that and Doctor Smith said that and what do you think about Jones and Smith and their opinions."
Well, that's the wrong way to go about it. I don't anticipate it happening here. I don't think it has happened in this trial, but again, I don't know all the ways in which a

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question can be phrased. Of course, I am going to stop now because I can think of several ways that a person might be able to get into that sort of thing. I am not desirous of getting you to ask these sort of questions, so I am going to hush. The point is that I am going to accept this man as an expert and will so be designated.

The other objection about the use of the sample, staining, slide, which Mr. Reilly indicated in his submission was simply for the purpose of showing the jury what one looks like, what one looks like and not to be any implication that this is a slide that deals with Mr. Allen personally or his body or organs, that seems to be all right as an example. It would be careful to make the jury understand that. If I am asked to give an instruction to the jury on that, I will do so. I don't think there is, but that can be taken care of.

Otherwise, the fact that Doctor Hensley did not do

stained sliding analysis -- I know that's not the correct terminology, but I think you all know what I mean -- the fact that he did not do that may be thoroughly inquired into on cross-examination, his reasons for doing it, his reasons for not doing it. That can all be brought out and that can be a subject matter to the jury as to the weight they should give to his opinion. It may be that he should have done that or shouldn't have. That can be brought out on cross-examination.

Just as in Judge Posner's opinion here, it's quite clear in the Sheman case that all of these things can be flushed out, and the person's reason for not doing something would be important or as important as some of the reasons for his opinion in certain other areas.

Here, well, the person will be qualified as an expert.

It's 10:20. Let's take a five-minute recess and go from there.

MR. GROSSMAN: We are to consider now that Doctor Hensley won't be spoken to about these rulings?

MR. REILLY: I wouldn't talk to him anyway. Had not anticipated asking him any opinions about Doctor Hammar. I don't know of a reason why I should forewarn him of Your Honor's thoughts.

THE COURT: Let me cut to the heart of it. Let's don't talk to him. Marshal, tell him that we are sorry we held him up. He can go to the rest room and we will see him in five

or ten minutes here. Thank you, gentlemen.

[There was a short recess.]

THE COURT: Bring the jury in, Marshal.

MR. REILLY: Your Honor, may I bring the witness in?

THE COURT: Yes. Please.

[The jury returns to the courtroom.]

THE COURT: Thank you. Be seated, please. Doctor Hensley, please resume the stand.

THE WITNESS: Yes, sir.

THE COURT: Ladies and gentlemen, the Court has qualified Doctor Hensley as an expert in the field of pathology and, therefore, is entitled to express opinion testimony.

Mr. Reilly.

DIRECT EXAMINATION (Cont'd.)

BY MR. REILLY:

Q. Doctor, can you explain to the jury what the rule of a pathologist is when dealing with a patient that is suspected from suffering from cancer?

A. Usually those of us in anatomical pathology have the ability to examine tissue removed from the patient for the

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purpose of diagnosis or in the course of treatment of tumors.
We look at those organs and tissues with the unaided eye and then we cut rather small blocks of tissue and process them so that eventually they can be cut on a machine called a microtome in slices so thin that you could read a newspaper

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easily through them.
After that we stain them and look at them under the microscope and we judge whether or not cancer is present, and if so, what type, if we can. We can't always tell what type, but we try.
Q. Doctor, these pieces of tissue are pieces of people's body?
A. Yes, sir.
Q. They are taken from the person's body?
A. Yes, sir.
Q. You explained that they are sliced thin?
A. Yes.
Q. Mounted on glass slides?
A. Yes.
Q. You look at them first with your naked eye?
A. The naked eye examination precedes the -- there are two steps. First, when the tissue is removed from the patient, frequently, even in the operating room during surgery, we will look at the tissues, either after they are removed or while in the body, and make a preliminary judgment.
Q. Doctor, when you look at this tissue under a microscope, do you look at it under different powers under the microscope?
A. Yes.
Q. Explain that to the jury.
A. Most pathologists will use a microscope that has what is known as scanning power, low power and high power, and

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occasionally they will use a lens that is ultra high power, which we call a merchant lens.
The scanning power will magnify the tissue that we are looking at usually eight times. The low power ten times and the high power forty times.
Q. You say you try to determine whether or not the patient has cancer?
A. Yes, if that's the problem posed to us. What we do is look at the tissue and try to distinguish between the malignant cells to be cancerous. Usually those are not difficult.
Q. Does the degree of difficulty change depending on where it comes from in the body?
A. It does. Matter of fact, the greatest limitation to our work is the selection of the biopsy by whomever obtains it. Usually the person obtaining the biopsy is the surgeon or radiologist or internist.
If they are using a needle to shove into the organ or tissue and pull out a very thin plug, sometimes it is so skinny, as it were, that we don't have many cells to look at in a cross-section. That can be very challenging. Usually we can tell if cancer is present or not, but in those cases it may be difficult to establish exactly what kind of cancer it is, especially, if the biopsy comes not from where the cancer originated, but from some remote location from that, which we call a metastasis.

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Q. Metastases are ordered to determine where the origin of the cancer, or what type of cancer it is?
A. Yes, you see, ideally, the biopsy should contain the normal tissue as well as the cancer. Often we can see transition from the normal tissue to the cancer, we can observe it under the

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microscope. When that requirement is met, we can almost always tell whether the cancer originated at that particular site. We can usually tell the cell type as well.

In point of fact, very tiny biopsies are obtained with a needle, very small biopsy may remove only the cancer, then we can't see it in the context of the organ in which it could have originated or might just have spread to.

Q. Is the pathologist the final determiner of what the patient's condition is?

A. No, we make what are called anatomical diagnoses, just as a radiologist makes a radiological impression or diagnosis. We are one group of the team that works with the physicians called the attending physicians. We, like the radiologist and other medical subspecialists, report to the attending physician. Of course, he has the final judgment as to how to use these various blips of data and information and put them together, establish a diagnosis and treat the patient.

Q. Doctor, if you can't determine by these standard methods, at looking at the specimen with your naked eye and then under the microscope, what the basic nature of disease is, are there

other tools available to assist the pathologist in trying to determine what the basic nature of the disease is?

A. Yes, sir, there are a number of things that we do. Usually the first step is to talk with the person that did the biopsy or the attending physician. We talk the problem over and find out if there is critical information that was not received by us on the requisition forms to us that might be helpful in planning further testing.

On the basis of that kind of interchange, we then decide what further testing might be indicated, and we might use conventional immunohistochemical studies and we might use immunohistochemical studies to accomplish that end.

I want to emphasize that the clinical discussion is useful, but the final determination of how to pursue an anatomical diagnosis and to report it is still the determination of the pathologist, the report, can either be accepted or rejected by the attending physician of that patient based on his overall view of what we are doing.

Q. The person with the overall view is the person you referred to as the attending physician?

A. Yes, whoever is really responsible for taking care of the patient and knows the most about it. We may also review the x-rays and we may look at other parameters. We may recommend blood chemistry tests that area useful in some cancers. There are a variety of things that we can do to try to arrive at a

diagnosis that is useful to the patient and his care.

Q. You mentioned histochemical and immunohistochemical stains. The jury has heard a little bit about that already. Could you briefly explain what those two modalities -- that's a big word -- those two researches are that are available to pathologists to help them arrive at a diagnosis?

A. Let me say first we use a standard stain called hematoxylin, which we refer to as H & E, and I might be apt to use those initials, but I mean a standard stain, if I do that. That's the basic step. And it's the most important step in the evaluation of the biopsy under the microscope.

If we find there are features that we observe by that method, they could be brought out better by a specific chemical means, then we use the approach called histochemistry. Histochemistry, in essence, is to create a specific chemical reaction within the tissue that leads to a specific color.

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Q. You mean plain color like blue or red or green?
A. Exactly.
Q. Okay.
A. So we can then compare the H & E, the basic stain, with the histochemical stain that sees what it tells us about the tissue. That's often quite useful in determining the nature of the tumor and the cell type.
The other thing that you asked about is immunohistochemistry and that is really fundamentally

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different. An immunohistochemistry we are dealing with specific chemical reactions, specific antibody reactions.
Q. Can you explain what an antibody is?
A. Yes. You all are sure that if you get sick with an infection, antibodies appear in your blood and help you to combat that infection. If any of you have the misfortune of having an organ transplant, you pretty quickly develop antibodies to that organ which have to be controlled by appropriate medical treatment.
In essence, what we do in immunohistochemistry is to place into an animal uses of tissue or organs or cancers or whatever that we want an antibody to. Then the animal has blood removed and the serum is removed, the antibody is isolated. Then we tag the antibody with a dye, and we can stain those constituents, what we have on the slide, with those specific antibodies. That method is more selective specifically in some ways than histochemistry and in other ways it isn't. It is proved to be very useful to us in the diagnosis of tumors.
Q. Doctor, if you have a specimen of tissue taken from an ideal location like the primary site of a cancer, do pathologists ordinarily agree on the interpretation of what the pathology shows?
A. Well, in a large percentage of cases, yes. In tumors that are atypical or from remote science -- by atypical I mean don't

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have the conventional patterns -- in that case a very capable pathologist, making different opinions, based on a small biopsy and you may have to solve the question by the remains.
Q. Doctor, in that answer you used the phrase from a remote site. Does that mean metastasis?
A. Yes, sir, that's what I meant.
Q. If a specimen is taken, which is clearly a metastasis from a location distant in the body from where the primary arose, whenever that may be, does that increase the probability that pathologists may disagree on the interpretation of the pathology?
A. It surely does. For a number of reasons, including the fact that usually the biopsy of metastatic regions is accomplished by taking out just a little bit of tissue, because it isn't meant to be absolutely diagnostic.
Secondly, you can never seal the transition from the normal tissue of cancer because there is no transition to observe in the case of a metastatic lesion.
Q. Why is that?
A. Let's take, for example, lung cancer of bronchiogenic type --
Q. Doctor, would it be of any benefit for you to use a human anatomy figure to demonstrate this for the jury?
A. I don't know. If you have --
Q. I think we have --

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A. I want to emphasize that I just arbitrarily selected one.

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What I am about to say could apply to any organ.
Q. Did -- if you could step down and describe to the jury what you meant by taking a specimen from a distant site.
[Witness exits the witness stand.]
BY MR. REILLY:
Q. Doctor, I am going to have to ask you to use this microphone.
A. Sorry.
This is not a perfect representation of the point I would like to make.
Most lung tumors that are central -- by central I might mean behind the heart -- they originate from the bronchial tubes. Hope you forgive me for the skewed drawing.
What I meant to show here is the windpipe comes down and divides into the bronchial tubes. When cancers originate in the central regions of the lung, they do it from the mucous membrane right here. The lines of these bronchial tubes.
If you were to take a biopsy here, you would see the mucous membrane and then you would see the tumor originating from it. Prior to the mucous membrane would be thick and abnormal, most of it would be thin and delicate.
If I take a section like this and look at it under the microscope, I can tell that I am looking at the bronchial tube. I can see the beginning of cancer here, and the advanced cancer

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here, no problem. I can tell you that it started from the lung.
On the other hand, let's say there is a metastasis from that same cancer cell to the lymph node. The lymph nodes are located here between the bronchial tubes. If that cancer forms a metastasis to those regional lymph nodes and I take a biopsy from here, then the only thing I can see is a lymph node tissue and the cancer in it. I have no idea where it came from. I can tell that it didn't originate from the lymph node because epidemiological tumors are distinctly different. I couldn't begin to tell you for sure this is lung cancer from a small biopsy of that metastatic site.
Q. Does it become even more true if you are dealing with a tumor that is found in a bone in the foot?
A. Yes, that's certainly true, because when metastatic lesions reach the bone, the bone around the cancer is often destroyed and that induces fractures.
Q. Would it help to describe that?
A. I don't think there are any bones there.
Q. Can you draw what it would look like when you look at a bone specimen?
A. Sure.
I shouldn't be so glib. I may not be able to do it. This is a crude drawing of the human femur. Mr. Allen, which you know, had a tumor in his femur, in addition to the cuboid

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bone in the foot, which was the first one that we learned about.
When the metastatic cancers hit the bone, they begin to enlarge progressively over time. When they do, the bone will actually break. You might even need a cast, you know. When that happens, all the bone tissue here, which I am going to schematize with little dots, falls right into the cancer.
Q. Doctor, could you move just a little bit so that the jurors can all see?
A. Sorry. When a fracture occurs, the bone will fall into the tumor sort of obscuring what you are going to look at, and secondly the cancer often obstructs the blood flow in the bone.

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And bone is extremely sensitive to the blood flow supply. Also the tumor has necrosis in the advanced stages. It doesn't cure it, but a large amount of tumor dies. Obviously, biopsy, in regions like this, would be harder for us to interpret.
Q. Thank you, doctor.
Doctor, I would like to talk to you about this case, the tissue of Bob Allen. Tell the jury what you did in connection with this case.
A. Well, I reviewed the slides that were prepared at Cedars. Also --
Q. We have talked about Jackson Memorial Hospital, we have talked about -- could you explain to the jury where Cedars is?
A. Cedars is affiliated with the University of Miami, Jackson

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Memorial Hospital Center. It's located directly across the street from Jackson, certain of its other buildings, including Sylvester Center for Cancer.
Q. Okay.
A. Doctor Civantos spent most of his time looking at material from patients that were biopsied and had been admitted on the University of Miami service. He had directed the preparation in his laboratory of the H & E stamps that I previously described. And I examined those subsequently -- no, at the same time. I examined the slides prepared in Doctor Nadji's laboratory in Jackson Memorial Hospital.
Q. Do you know Doctor Civantos?
A. Yes, Doctor Civantos has been with the department of pathology for many years. I worked him since about probably 1978.
Q. Tell the jury whether or not you reviewed any additional -- did you review the pathology reports prepared by Doctors Civantos and Nadji?
A. Yes, sir, I did.
Q. Did you review any additional pathology slides prepared by anyone else?
A. Not during the lifetime of the patient. Subsequently I saw --
Q. You mean not slides prepared during the lifetime of the patient?

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A. Yes.
Q. Slides that appeared after the patient had died?
A. Yes.
Q. Did you review the medical records in this case?
A. I did.
Q. Did you review the pathology reports before or after you reviewed the slides prepared by Doctors Nadji and Civantos?
A. After.
Q. Is that your standard practice, to review the slides first and the reports later?
A. Yes.
Q. Why is that? Why do you do that?
A. Well, in order to contribute to the pathology of the patient, the pathologist has to make his own independent analysis of the patient, and he shouldn't be trying to base the diagnosis on the clinical history or other findings of the patient. Those data may be useful, but the first impression should be your own, and the final report should be an independent judgment to be accepted or rejected by the attending physician as he deems appropriate.
It wouldn't be good, would it, if we diagnosed what other people were thinking. There would be no reason to evaluate a biopsy if they weren't actually looking for an

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independent reason.
For that reason, I prefer to look at all of the slides
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knowing all the indications, age and sex and where the biopsy would have come from.
Q. You mean in the body?
A. In the body. And then I would make a preliminary, but fairly firm, diagnosis; and then I can ask about the history of the resident pathologist in training beside me at the microscope or the attending physician who walks into my office, you see.
Sometimes that is so important because first impressions can be wrong. I may get a clue that I was on the wrong track. Then I have to decide what strategy to pursue to refine my personal diagnosis that may be reported.
Q. Doctor, you may have answered in that last answer, as a teaching tool that you used as a professor of pathology, a microscope that two people can look through at the same time?
A. Yes, we use those. That will accommodate two and as many as ten, and then we have a closed-circuit television that would accommodate thirty or more.
Q. Tell the jury, when you were a professor of pathology, how you would engage in that kind of teaching tool.
A. You see, the normal procedure goes like this. This is a daily exercise for surgical pathologists.
The day before a case is checked out, the resident pathologist exams tissue that are removed from the patient, prepares them, directs their preparation, in a way that I
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previously described. If there are any questions or problems, he walks into my office and asks me to come over and help him. The next day, the histotechnologist provided that person with a large number of slides from a large number of people. He has the requisition form, or she has, actually. In recent years we trained more women than men in pathology. It's a very good field for women.
They bring the slides in. They have a brief clinical history. If they have run across any complex problems, they have gone to the ward that they have charts with any technical data. I look at slides and -- together with the other person looking at exactly the same thing through the microscope, and we discuss things and I teach them and give them my diagnosis. And I say, "Well, what have you got to say about that?" Sometimes -- not uncommonly but sometimes the resident will say, "Wait a minute, we are barking up the wrong tree," and then he will give me some facts and I will have to reconsider.
It's a one-on-one experience.
Oh, often, the attending or another doctor will be in my office at the time. Maybe it will even be him to be showing me the slide, because they are so impatient sometimes that they can't wait for the normal process. So I don't do it always the same way. I am doing it with the attending physician.
Q. Doctor, you looked at the tissue slides prepared by Doctor Civantos?
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A. I did.
Q. Tell the jury what interpretation you made of those slides.
A. I essentially agreed with Doctor Civantos that the biopsy of the bone represented a metastatic carcinoma with some clear cell features. It was not further classifiable with certainty. But the appearance of the tumors suggested that the most likely orientation was from the kidney.
Doctor Civantos, in that report, I think, suggested

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that he had in mind that it could maybe be a squamous cell carcinoma too. He decided to use certain immunohistochemical stains that he hoped would clarify that issue. I would agree with his prudent approach there.
Q. Doctor, I didn't have it centered very well, but I have now put on the screen the report of Doctor Civantos. Can you tell the jury what the significance to you of partially clear cells was in this case?
A. Well, "in this case," is the key phrase.
Doctor Civantos -- I knew that the tumor was a bone, therefore it was metastatic because carcinomas never originate in a bone.
Q. Why is that?
A. Carcinomas originate from epithelial cells.
Q. You have to tell the jury.
A. Epithelial cells are cells that cover the surfaces of the body, like our skin, our mouth, our trachea and bronchi, as I

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just pointed out in that demonstrative, and mouths and so on. These are the tissue that give rise to carcinoma. Tissue of that kind are not found in bone. So it's one of the few times that you can say for sure there is no possibility that a carcinoma can originate primarily in a bone. So we knew it was metastatic. That was a very important point conceptually.
Secondly, we knew that it was a bone from the extremity.
Q. Extremity?
A. Pardon me. It was a bone from the arms and legs. That is very important, because, there is a tendency for certain cancers to metastasize beyond the elbows or knees. For most tumors that's pretty rare, even though it's metastasized to the bone.
Of those that metastasize beyond those locations, kidney, and the urinary system are number one. The others are kind of far down on the diagnosis list, you know, thyroid cancer. You would always have to consider prostate on men and on women carcinoma in the breast because those two cancers metastasize to bone. Usually it's in the trunk, between your pelvis and your neck. They don't commonly metastasize below the elbows and the knees.
Nonetheless, it was prudent of Doctor Civantos to pursue that differential as a real possibility.
Q. Is the nesting pattern significant in this case?

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A. It shows the epithelial nature of the tumor. The nesting pattern is somewhat against it being adenocarcinoma. Adenocarcinoma -- I am sorry to use these terms, but adenocarcinoma is the type of cancer that could spread to the bone.
I mentioned the possibility of thyroid gland and the breast. Both the thyroid and the breast have little structures that are frequently called acini or little glands. When they metastasize to those locations, you look for those structures. If they are present, then you really have to worry about something other than the kidney.
That was not the case here. What we found was this nesting pattern without any clear-cut evidence in the H & E sections of any gland formation. So the best we could do is just say that this is a poorly differentiated carcinoma, meaning you are not sure exactly what tissue it came from, with clear cell features in a bone or the foot. And put all of that together to a pathologist, you are practically talking about cancer of the kidney metastatic to bone.

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So that was Doctor Civantos' first impression here, but he hadn't looked at it further.
Q. Doctor Civantos ordered immunoperoxidased stains, correct?
A. He did.
Q. Those were performed by Doctor Nadji's laboratory?
A. Yes.

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Q. Did you review those slides as well?
A. I did.
Q. Did you review those slides before you saw Doctor Nadji's report?
A. Yes.
Q. What conclusion did you come to in connection with those stains?
A. Well, I essentially agreed with Doctor Nadji about the end result of his staining was still consistent with the tumor had originated from the kidney.
You understand that these tests don't establish diagnosis; they simply provide additional information that helps you make a professional judgment. The tests that were used could not absolutely rule in and out any of the diagnostic consideration, but I agreed with him that the results are still consistent with the original diagnosis of the tumor most likely originating within the kidney.
Q. These tests seemed appropriate to assist Doctor Civantos in making a diagnosis?
A. Yes, I think they are a commonly accepted battery.
Q. Are these slides properly prepared?
A. Yes, I found no fault with them.
Q. Ultimately at this juncture what diagnosis did you arrive at?
A. At this point I felt we were dealing with a poorly

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differentiated carcinoma with clear cell features most consistent with an origin of the kidney.
Q. Did this rule out other possible tumor sites?
A. No, we couldn't say -- it was a very small biopsy -- with certainty. You have to bear in mind, A, it's from a metastatic site; and B, in largest dimension, it was less than half an inch. In the other dimensions, the pieces of tissue were more like a tenth of an inch. We didn't have a lot of material to deal with. It wouldn't have been practical to go further.
Q. Do you know whether or not any more specimens were taken from Mr. Allen's body during the remainder of his course of treatment in the ensuing nine and a half months?
A. I believe he had some cytology examinations of pleura fluid, but he never had another biopsy, to the best of my knowledge.
Q. You said you reviewed the medical records. Did Mr. Allen initially get treated for kidney cancer?
A. No.
Q. His treating physician was Doctor Shridar?
A. Yes.
Q. What did Doctor Shridar treat him for initially?
A. As I understand his chemotherapy and radiation regimen, it was more appropriate for treatment of the lung cancer than the kidney cancer.
Q. Can you determine, from your review of the medical records,

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whether or not Doctor Shridar, in those early months, relied on the pathology or relied on something else in order to design his treatment?
MR. GROSSMAN: Objection, Your Honor, the state of

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mind of someone else.
MR. REILLY: I think, Your Honor, it is readily apparent from the medical records.
THE COURT: Then I am sure you can argue it to the jury without him to tell you what's in there. Sustained.
MR. REILLY: I will rephrase the question.
BY MR. REILLY:
Q. Was the treatment that was provided to Mr. Allen consistent with a diagnosis based on these pathology reports?
A. No.
Q. What was it consistent with?
A. Well, the chemotherapy that originally he was on was consistent with treatment for adenocarcinoma. I presume that, in this case, the thought was adenocarcinoma originating in the lung.
Q. All right. At some point in time did the treatment actually become treatment for kidney cancer?
A. Yes, at the end.
Q. All right.
Doctor, in connection with this litigation other slides were prepared by Doctor Hammar, correct?

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A. Yes, sir.
Q. Did you have opportunity to review those as well?
A. I did.
Q. Were those slides prepared appropriately as well?
A. Yes, the slides that I examined were of good quality except for the mucicarmine slide.
Q. Doctor, can you tell us whether or not in your review of those slides whether you agreed with -- strike that.
Did you look at those slides before you saw Doctor Hammar's interpretation of those slides?
A. Yes, sir, I did.
Q. Did you come to conclusions regarding what -- your interpretation of those slides?
A. Yes, we differed on some points. I made my own conclusions and then I read his. There are some differences.
Q. What I really would like to focus on now, quite frankly, is the difference of opinion, of interpretation, between you and Doctor Hammar of those slides.
Can you tell the jury which slides you disagreed with Doctor Hammar's interpretation of?
THE COURT: Objection?
MR. GROSSMAN: Objection.
THE COURT: Sustained.
BY MR. REILLY:
Q. Can you tell us what interpretation you made of the

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mucicarmine stain?
A. That it is negative.
Q. Do we have some blowups here of the mucicarmine stains prepared by Doctor Hammar?
A. I believe so.
Q. Let's put those up.
Doctor, are those blowups of the seven mucicarmine stains performed by Doctor Hammar?
A. Yes, they are.
Q. I am going to hand you another slide and ask you if you can identify that.
A. Yes, this is what we call a controlled or standard slide.
The College of American Pathologists mandates that if you do a mucicarmine stain -- or another special stain, for that matter -- on a patient, they have to run a piece of tissue

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that you know contains positive cells and negative cells so that you can tell which cells are positive and which are negative on the basis of certain knowledge. Usually, mucicarmine use an appendix or colon or even a small bowel.

Well, if you don't have a controlled slide, if you only have the slides of the patient, you don't know for sure that the technique was executed properly. The criteria of evaluating whether a slide is positive or negative depends on, in the case of a mucicarmine, identifying the proper color. Also, it depends on identifying where the cells are. Are they

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in the cancer cells that you are trying to stain? Are they in different cells?

It wouldn't do you any good to call something positive in the case of a cancer that you tell us you saw staining red are not cancer cells, would it?

So we are required to keep a slide like this in the file with the patient's slides so that if somebody wants to make an independent judgment of your work, he can go to that standard, which we call the controls. Unfortunately, Doctor Hammar did not provide his controlled slide, so we do not know whether it was properly executed or not.

MR. GROSSMAN: Objection, Your Honor.

THE COURT: The objection is sustained.

Doctor, try to refrain from commenting upon what the others did or did not do. You do not have a controlled slide from Doctor Hammar. That part is admitted. The other part of the answer is deleted. Go ahead.

BY MR. REILLY:

Q. Doctor, can you tell us where your controlled slide came from?

A. This was a slide that was prepared at Jackson Memorial Hospital some years ago. When I left there I took a series of controls so that I would have in my office slides that were acceptable controls. These slides were actually made by my wife who was the technical director of histotechnology at

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Jackson Memorial Hospital.

Part of her capacity was to produce acceptable control slides and to teach students in histo technology and how to do it.

Part of my job there at that time was to take the slides that the students had prepared and certified that they did their work properly and that the slides were good and then submit them to the American College of Clinical Pathologists so that the students could become certified in histopathology. So I am very familiar with this technology.

Q. Doctor, could you explain to the jury whether or not these slides depict a positive or negative mucicarmine stain?

A. You can't actually use a phrase that is applicable because, A, we don't have a controlled slide. So it's dangerous to try to interpret these at all without the control.

B, what do you mean by positive or negative?

A positive reaction is a reaction like this, a controlled slide, where you see that red mucin. I have to know whether that mucin is inside a cell or not, and I have to know what part of the tissue it is in.

Here, I can see a gland -- I am making up the mucosa. This gland is positive, but you don't say the slide is positive. The reason you don't is that many of these cells have nothing to do with mucin. These little cells are white blood cells, lithocytes, you can't count that. If you found

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one or two positive cells out here, it wouldn't mean anything.
So we don't say the slide is positive. We say it's either mucin-producing or it's not.
Q. Can you tell the jury whether or not your interpretation of the slide is that it is or is not a mucin-producing tumor?
A. No, this is not. We have here one of those masses that Civantos mentioned. I actually counted the cells in such mass. I was able to count, in these pictures, about four hundred and forty tumor cells. If this were to be accepted as positive, right here, a little bit of pink, and you added up all the others -- and you can't tell whether that's a tumor cell, but if you were being liberal and you counted it, you would come up with four out of four hundred and forty-eight cells, which is less than one percent positive, that's not a mucinous tumor.
A mucinous tumor, as defined by the dictionary, contains substantial mucin.
Q. Doctor, did you look at the other -- now, this is not an immunohistological stain, is it?
A. No.
Q. This is called a histochemical stain?
A. Yes.
Q. How long have you been reviewing mucicarmine stains?
A. Well, since the 1950s.
Q. Doctor, the immunohistochemical stains that were done by Doctor Hammar, could you tell us whether or not, in total, any

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of those immunohistochemical stains ruled in or ruled out kidney or lung cancer?
A. It did not.
Q. Did the results of this mucicarmine stain, based on your interpretation of it, rule in or rule out a kidney or lung cancer?
A. It is supportive of the original diagnosis this is not a mucin-producing tumor. Since there are clear cells, these are excellent representation of clear cells, and they are negative. It supports the original diagnosis of cancer originating in the kidney. It by no means proves that, but it supports that.
Q. Well, doctor, staining has been referred to as an adjunct, correct?
A. Yes, as a matter of fact, in the -- pardon me.
Q. Would you like some water, doctor?
A. Yeah. In the Armed Force's Institute of Pathology manual, on the diagnosis of lung tumors --
Q. Actually, you may be able to sit back down.
A. -- and that's one of the two most often used references for pathologists. It explicitly states that the diagnosis of lung cancer should not be based on immunohistochemistry or on immunohistochemical stains. The reason for that, as they point out, the cancers like this originate from cells that can grow in a variety of directions. So a little bit of mucin in a tumor does not make it mucinous. It would be a mistake to make

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that interpretation. Those sources admonish us to be careful not to overrate the histochemical stain.
Q. Doctor, I didn't mean to interrupt you.
A. I am done.
Q. Doctor, you reviewed the medical records in this case?
A. I did.
Q. And did you determine whether or not a single tumor was found in the kidney of Mr. Allen?
A. Yes, eventually that proved to be the case.
Q. Based on that knowledge, is that consistent with a primary tumor occurring in the kidney?

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A. Yes.
Q. Could you explain to the jury why that is?
A. Well, in metastatic disease, from lung cancer, the kidneys are not very commonly involved by metastasis, but they certainly are often enough as not surprising.

But the colonies of cancer cells that reach the kidney from the lung come by way of the bloodstream, and of course, they go to both kidneys and they go to all parts of the kidney. So as a rule, if you are dealing with a primary lung cancer metastatic to kidney, then they have multiple lesions and they effect both kidneys.
Q. Doctor, did you have any desire to do more immunohistochemical staining in this case or more mucicarmine staining or any other kind of staining?

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A. No, I think the work done is as much as can be done. You can never make a diagnosis based on -- I shouldn't say you can never, but I should say that in the context of the differential diagnosis of lung cancer versus kidney cancer, you can never wholly rely on any one of the tests that we used here of any combination.

In fact, the most significant testing that was done is not one of the immunohistochemical preparations in the modern era. The most significant test was the mucicarmine, and that, in my judgment, is negative and favors renal cell carcinoma. Had it been a clear-cut, positive reaction, had the tumor cells here in appreciable mucin-production, my view would be otherwise, but it isn't.
Q. Doctor, I think you already indicated that kidney tumors can metastasize to distant extremities, hands and feet?
A. Yes.
Q. Can kidney tumors of the size of one centimeter metastasize to hands and feet?
A. They can. That brings up another point, if I may.

The size of Mr. Allen's tumor recognized in the left lung initially was under two centimeters.

According to the World Health Organization classification, that means it was a small cancer. In point of fact, they say of some small cancers with features of adenocarcinoma, like so-called bronchioloalveolar carcinoma,

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that perhaps should be called benign until they are greater than two centimeters because it's uncertain that they metastasize at all.
Q. Doctor, there were lesions found in the lungs and bones of Mr. Allen, correct?
A. There were.
Q. Was the distribution of metastasis in this case, in Mr. Allen's body, consistent with a renal cell carcinoma?
A. Yes.
Q. Can you explain to the jury why that is?
A. As I have indicated, most of the tumors that have a predilection to metastasize in the skeleton do so in either the torso or the cranium. Particularly the spine of the torso and in the neck too. Some of them will metastasize to the bones in the thigh and the upper arm, but very few metastasize below the knee or below the elbow. Kidney cancer is predominantly a tumor that does that, in my experience.
Q. Are there different kinds of kidney cancers?
A. Yes, there are.
Q. What type of kidney cancer did you diagnosis in this case?
A. I felt it was consistent with the most common variety of kidney cancer, namely clear cell carcinoma. Sometimes referred

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to as renal cell carcinoma.
Q. Doctor, how important in this case was it that there was no biopsy taken from the lung or the kidney or no autopsy performed?
A. From my standpoint, as an anatomic pathologist and the person who studied the national history of disease at some length in an academic setting, it's very unfortunate, because in point and in fact, we will never know for sure what the story is here. Without being able to examine the tumor in the lung and the kidney and looking for the telltale sign, the transition, from cancer to abnormal tissue to normal tissue, without establishing that, we will never be completely certain. All we can do is make our best medical judgment.
Q. Doctor, are you an expert in the causes of kidney cancer?
A. Not really. I, of course, have some familiarity with the literature, but I wouldn't call myself an expert.
Q. Doctor, in all of the opinions that you have given today in this case, have been to the degree of reasonable medical certainty?
A. Yes, sir.
MR. REILLY: No other questions, thank you.
THE COURT: Perhaps before taking a -- if this does not interrupt, we will take a short recess before commencing cross? Thank you.
You may step to the jury room, ladies and gentlemen.
[The jury leaves the courtroom.]
THE COURT: You are free to step down, Doctor Hensley.
THE WITNESS: Thank you, Your Honor.

[There was a short recess.]
[The jury returns to the courtroom.]
THE COURT: Cross examination.
MR. GROSSMAN: Judge, may I ask my first question from over here so I can read my daily --
THE COURT: Yes.

CROSS-EXAMINATION

BY MR. GROSSMAN:
Q. Doctor, so that you know what I'm going to do, as our court reporter is typing out your testimony, it comes up on each one of the screens, computer screens, that counsel has as well as the Judge. I really want to be sure about something that you said. Okay?
A. Yes, sir.
Q. If I can take the portable mike and just stand back here. It even gives you the time you said it and the second you said it. After you were asked some questions about stains, you were asked this question this morning: "What conclusion did you come to in connection with those stains?" And you said, "I essentially agreed with Doctor Nadji about that at the end resulting of the staining was still consistent with the tumor will -- and this is the way it's spelled -- that had originated from the kidney."
Now, let me walk back over here. This is so that there is no confusion. Do you know that Doctor Nadji came into court and testified in this case; do you know that?
MR. REILLY: Objection, Your Honor.
THE WITNESS: Yes.
THE COURT: I have been sustaining objections about commenting on the other people's testimony.
MR. GROSSMAN: Yes, sir, but this is a follow-up to a question that was allowed as to his belief that Doctor Nadji

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said it was kidney cancer.
MR. REILLY: I object, Your Honor. You didn't permit me to do --
THE COURT: Pardon me. The jury has heard Doctor Nadji's testimony. That will all be argued to you. This witness should tell us his testimony. I didn't hear any objection to that question. So I couldn't rule on it. If it was some comment on some other witness -- but I don't want the witnesses commenting on somebody else's testimony. They can say what they think. The other guy says what he thinks. You all will decide after listening to argument and instructions on which one you -- if the opinions differ, which one you believe. All right. Let's move on.
BY MR. GROSSMAN:
Q. Doctor Nadji is a pathologist at the University of Miami?
A. He is.
Q. Doctor Civantos is a pathologist at Cedars Medical Hospital?
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A. I am not sure whether Doctor Civantos was in private practice at Cedars at the time that the biopsy was done.
It's my understanding that he retired just about that time and stayed on at Cedars as an attending pathologist. I always think as -- Doctor Civantos as a professor in the department because that's the rank that he held while I was there.
Q. In a moment we will get into how many professors and assistant professors that there were. But for now, I am asking these questions because I want to be sure that although you were in Virginia, having retired two years earlier when this occurred, this being Mr. Allen's illness and death, that neither Doctor Civantos nor Doctor Nadji nor anyone else affiliated with Mr. Allen's care and treatment requested your help in arriving at the diagnosis in this case.
A. That's absolutely correct.
Q. The only time that you were contacted in this case and the first time you were contacted in this case was by the defense attorneys from the Shook, Hardy firm, correct?
A. That is correct.
Q. You have testified on behalf of tobacco, I think you said earlier, and I don't want to put words in your mouth, but somewhere between five and seven different cases, including other cases in Dade County?
A. That's about right.
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Q. You have never testified on behalf of the person who was ill?
A. Well, I couldn't, Mr. Grossman, because I have never been asked to.
Q. I see. So if you were asked to, you might consider doing that?
A. If an attorney contacted me, I would probably talk with him and make a judgment at that point.
Q. I see. Along those lines, along those lines much credit was taken for, I think you were asked questions by counsel about hundreds of pathologists in the State of Florida, or words to that effect, or different institutions in the State of Florida?
A. It may be sir, but my recollection is that we were talking about the total number of pathologists that I have trained in the state and elsewhere. I included those around the country as well.
Q. Some of those people trained here at Jackson Memorial

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Hospital, correct?
A. Yes, sir.
Q. You may not have been involved in their training?
A. Well, virtually all of those who were in anatomical pathology, fellowships in anatomical pathology from 1975 until 1995, I would have had contact with in teaching.
Q. You say contact or teaching. Who is the chairman of the

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department of pathology for the majority of the time that you were there?
A. All of the time that I was there, the chairman is Doctor Azorides Morales.
Q. You were not the chairman. Were you the vice chairman at any point?
A. No, in fact, there was no vice chairman, to the best of my knowledge.
Q. But it was Doctor Morales who was the chairman the whole time?
A. Yes, sir. He still is the chairman, I believe.
Q. He, of course, is a specialist in heart pathology?
A. Yes, and also electron microscopy and pathology soft tissue tumors.
Q. With respect to Doctor Morales and you, how many other members were in the department of pathology? Would you tell us, please?
A. I don't believe I can without taking a moment to think about it, because it varied substantially over the years. If you would like me to make an estimate, I will.
Q. Sure.
A. Well, when I first arrived in 1975, the department had disintegrated and was being rebuilt single-handedly by Doctor Morales. When I came on board there were perhaps six people in Jackson and three or four over at the Veterans Administration

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Hospital which required a team.
One of our first priorities was to recruit. We recruited a lot of good people. So, by the time I retired, I would estimate there were twenty-five to thirty pathologists on the faculty in the department of pathology.
Q. All right. At least a hundred, if not more, other pathologists who moved through the system, correct?
A. Resident pathologists, yes. More than a hundred, actually.
Q. One of those who stayed, and I think you said was asked to stay, was Doctor Nadji?
A. Yes, Doctor Nadji was definitely asked to stay.
Q. Is Doctor Nadji someone whose work you reviewed in the past?
A. Yes.
Q. So you have a good idea as to whether or not he is a competent pathologist?
A. I certainly do.
MR. REILLY: Objection, Your Honor. I believe you were permitting us to comment on the competency of other experts.
THE COURT: I will permit a yes or no answer. If you want to ask him the next question.
MR. GROSSMAN: Did he answer that, sir?
THE COURT: I have a good idea, he answered that one yes.

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MR. GROSSMAN: Thank you. I'm sorry, I could only hear the objection. I didn't hear the answer.
BY MR. GROSSMAN:

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Q. You started out this morning by answering questions about qualifications. Different pathologists have different areas of interest, don't they?
A. Yes, sir. That's certainly true.
Q. There is a recognized specialty in pathology called pulmonary or lung pathology; is there not?
A. I don't think so. I believe that there is no board examination on pulmonary pathology. However, there are certainly pathologists who restrict their practice to a certain extent in the area of pulmonary pathology. I think it would be appropriate to say that they are pulmonary pathologists, although they are not certified by any recognized board.
Q. So at the end of the day you recognize that there are people who restrict their practice and specializes in the specialty of the lung?
A. That even included me at one time, yes.
Q. How long ago?
A. It's reflected in my CV.
Q. I will get to it. I am sorry.
A. As I recollect, the work I did in hypersensitivity and pneumonitis began around maybe 1972 or earlier, perhaps 1970, '71, and continued while I was in Wisconsin.

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Q. So that we are clear, hypersensitivity pneumonitis, I think, were first uttered this morning. That's not an issue in this case, is it?
A. No. The answer that I just gave you, sir, is to reflect the work I did in that area. At the time that I was in Wisconsin I did pulmonary pathology, and initially in Miami as well. I did pulmonary pathology covering a wide range of conditions, including cancers.
Q. When you were in Wisconsin, was your chief field of interest within the lung hypersensitivity pneumonitis? Can you answer that?
A. Yes, I can answer that. I was a consultant pathologist working in that area, and I published in that area, but no, my interest in pulmonary pathology, in anatomic pathology, in general, were really quite broad.
Q. This is a book edited by David H. Dail and Samuel P. Hammar called Pulmonary Pathology, Lung Pathology. Have you seen this book?
A. Yes, sir. I'm familiar with that book.
Q. Do you consider this book to be authoritative in the field of pulmonary pathology?
A. With all due respect, it's very difficult for a physician to use the word "authoritative" in terms of literature. We are practitioners of medical science. Medical science is not authoritative. That said, let me add that I consider that to

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be a very good book. There are some chapters in there, including the one written on hypersensitivity pneumonitis, and I could rely on, certainly.
Q. Do you own the book?
A. Yes.
Q. Are you familiar with another book by Doctor David Dobbs, who was a professor of pathology at the University of Pittsburgh School of Medicine, and in particular called Diagnostic Immunohistochemistry? Do you know Doctor Dobbs? Do you know who he is? Dabbs, excuse me, D-a-b-b-s.
A. I am familiar with the name, and I probably read some of his papers. Also I am familiar with the title, but I do not own that book and I don't use it.
Q. Do you know if Doctor Hammar wrote the chapter in that

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particular book called lung and pleural neoplasms?
A. It's my understanding he did. My recollection may not be 100 percent.
Q. Would you like to see it or would you take my word for it?
A. Oh, I certainly take your word for it.
Q. The work called The Pathology of Lung Tumors by B. Corrin, C-o-r-r-i-n, who was the professor of thoracic pathology, the National Heart and Lung Institute in London, it's a book published here in the states in New York by Churchill Livingston. Are you familiar with Doctor Corrin's book?
A. Not that book. As a matter of fact, he is one of the

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authors of the book I cited earlier today, the Armed Force's Institute of Pathology Fascicle on Tumors of the Lower Respiratory Tract.
Q. Do you recognize Doctor Corrin as an expert in lung pathology?
A. Yes.
MR. REILLY: I object, Your Honor. I don't know that we are supposed to be recognizing people as experts. Authoritative services, there are texts and things of that nature, but not individuals. I object on that basis.
MR. GROSSMAN: That's my first predicate question, Judge.
THE COURT: Doctor, you may tell us, as an expert, whether or not you consider this man to be knowledgeable in this knowledgeable or expert in this field. However, you wish to phrase it.
THE WITNESS: Yes, Doctor Corrin is certainly recognized as an expert in that field. Having said that, it does not necessarily mean that I agree with all of his positions on everything. He is a very reliable and capable pulmonary pathologist.
BY MR. GROSSMAN:
Q. So you are familiar with his work, The Pathology of Lung Tumors?
A. No, in fact, I said before, counsel, I had not read that

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particular monograph, but I have read other works of his, not only in journals, but as you probably know, he was one of the authors of the World Health Organization Manual and Classification of Lung Tumors, which everybody has read, as I have said.
Also, the Armed Force's Institute of Pathology Fascicle which is a very influential book on the pathology of lung tumors.
Q. Yes, you did mention those. I wanted to be sure that you knew he was in both of those institutions, he had been prominent?
A. Yes, I know a bit about his background. Not much, but a bit.
Q. All right. I will ask you some questions about articles at a later time. I just want to establish what you know about the person.
I wonder if you ever had the occasion to read a publication called Nature Reviews. It's very recent, August of 2002, on cancer metastasis. Do you know this article or this publication?
A. I don't know, counsel. I would have to actually look at it. I read rather broadly. Just holding it up like that, I don't recognize it.
Q. I will bring it over to you in a moment. Just let me ask you, do you know who Doctor George R. Mundy is?

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A. No.
Q. Are you familiar with the University of Texas Health Science Center in San Antonio?
A. Well, superficially.
Q. So you don't know Doctor Mundy from there?
A. No, sir, I do not.
Q. This exhibit that you brought in today -- when I say exhibit, this has something, excuse me -- this cell and what this cell represents, did not come from Bob's body, did it?
A. No, this is a controlled slide that is required to interpret properly the mucicarmine stains on Mr. Bob Allen's body.
Q. Do you know if this slide that you say is a controlled slide came from a man or a woman?
A. No.
Q. Do you know the name of a patient?
A. None of that is relevant. The answer is no.
We never identified the patients as a manner of practice. The custom is to use a known positive control. We certainly do not identify another patient and file with the patient in question. I don't think that would be appropriate.
Q. Then, when you were asked a question about Doctor Hammar's control slide, which you haven't seen it, would his control slide look exactly like yours?
A. The very point is we don't know. If his control slide

looked like the slides that he stained for mucin, then what one should do is send that back to the laboratory and say "re-stain it because this is a failure." If it looked like my slide, which is acceptable, then he should say that the reaction product is negative.
Q. Well, you made a point. There's nothing I can do about that. But you have now said that if he had a control slide that didn't look like yours -- by the way, when you say yours, you didn't create this, did you?
A. It was done at the laboratory at the time I was professional director of this. The pathology done by my wife, who is a technical director. I have a very sound grasp of the quality of standards.
Q. All right. Is she a doctor also?
A. No, she is a registered histotechnologist and was acting as a teacher teaching how to do these preparations.
Q. So the person that did this slide whom you believe was the authoritative slide was your own wife, Mrs. Hensley?
A. That's the way it happened, yes.
Q. Would it be true that if anyone's control slide didn't look like your wife's slide, that they should send them back?
A. Mr. Grossman, this slide illustrates the criteria which are accepted by the College of American Pathologists and previously by the Joint Commission on Accreditation of Hospitals. Those criteria represent a true red color; and the localization of

mucin such that it can be easily recognized, whether it's in cells or not in cells; and thirdly, that it has on the same slide, cells that are known to be negative and known to be positive on the basis of fundamental anatomical considerations. This is what is in all the books. This is what is accepted by everyone.
If the control file, with any other patient, be it in Miami or New York or Berlin, didn't look very similar to the control slide I have shown you, it would be considered to be a failure and sent back to the laboratory for re-staining.

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Q. So that we understand, virtually any slide in the world that didn't look for this in a control slide would be, in your opinion, defective?
A. Not just in my opinion.
Q. But we are only allowed your opinion.
A. I'm sorry. I apologize.
Q. Yes, because you're the witness.
A. In my opinion, the world standard is met.
Q. In that slide?
A. Yes.
Q. And nothing else?
A. Right.
Q. And that, again, was Mrs. Hensley's work?
A. It was. I have a whole set of special stains that she did for my reference.

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Q. Okay. The curriculum vitae, the CV, the resume, so to speak, that you referred to both when you were asked questions and you told me to take a look at it, I have, the articles that appear in this, if you would like to see it, in fact, if I brought it up to you now, could you circle any articles that you have written on the subject of lung cancer?
A. There's only one, I think. I can cite it.
Q. Sure, when was it written? I will find it.
A. It's an early paper, before I left Milwaukee. It was probably about 1970 to '73. The title is Hypertrichosis Luginosa. If you like me to spell it?
Q. Sure.
A. H-y-p-e-r-t-r-i-c-h-o-s-i-s, second word, L-u-g-i-n-o-s-a.
Q. If you find it there, would you just circle it for me, please?
A. Oh, I will find it.
Q. Okay.
A. Does anybody have a pencil?
Q. Yes. I have one.
A. It's number 62. Let me just scan this real quickly. I don't think so.
Q. While you're scanning it, could I ask the same question, that you circle anything that you believe you wrote that concerns kidney cancer, renal cancer?
A. I have not published on kidney cancer.

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Q. Have not?
A. Have not.
Q. All right.
A. Would you like to have this back?
Q. When you're done with it.
A. I am done.
Q. So allow me for just a moment to return to the one that you circled.
A. Sixty-three, I think.
Q. Yes, let me just get there for a moment.
This was an article written in 1969 called -- and you will help me, I am sure -- Hypertrichosis Lanuginosa as a Sign of Internal Malignancy.
Now, assuming I could find that article.
A. You can.
Q. Assuming I could.
A. It's readily possible.
Q. Is that pertinent to Mr. Allen? Did he have this particular condition?
A. No, it's responsive to your question.
Q. Yes, I am asking you questions. The first question I asked

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you is, did you ever write anything about cancer of the lung, you said this article. I asked you about cancer of the kidney, and you said no. Now, I am coming back to this article.

Does this article deal with the issues in this case?

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A. No, except cancer of the lung, of course.
Q. Is this the type of cancer that Mr. Allen had, sir?
A. No, no.
Q. Now, you have, of course, said that to you that these stains that were blown up, that you put in front of the jury, excuse me, these slides put up in front of the jury, didn't look like control, correct?
A. Yes, I think that was evident.
Q. In your practice, let's just say instead of being a consultant for tobacco, for the defendants in this case, let's assume that you were Doctor Hensley and you were asked to try to find out what it was that Mr. Allen had; and let's just say that Doctor Nadji or Doctor Civantos said, "Doctor Hensley, what should we do to rule in a positive or negative study using this particular stain that we have discussed?" Do you remember its name?
A. Are you referring to mucicarmine?
Q. Yes, sir.

Are you the type of pathologist who routinely did mucicarmine stains after his practice?

A. It depends on what you mean by routinely. Naturally. It's a routine stain. That's what pathology laboratories use all the time.
Q. I am sorry.
A. In any case where it would seem appropriate to use it, we

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used it routinely.

Now, if we had a biopsy that showed conclusively a different cell type and there was no indication to use it, nobody including myself would stain it routinely by a mucicarmine. Nobody does that.

Q. I would like to talk about this particular case. If you could imagine with me that it's before your retirement and you were out here at Jackson as a pathologist and someone said to you, "Here is a specimen taken, we want to know if this is kidney, we want to know if it's lung," would you have ordered a stain like this to be done?
A. Not initially.
Q. Would you have ever done it?
A. That's a very hypothetical question, but the answer is yes.

Let me finish the first part of my answer. This man had a lesion in the cuboid bone of the foot. It brought to mind the possibility of kidney cancer. If I were going to critique my diagnosis, which I often do, I would probably have turned to something else other than the mucicarmine initially. Given the fact that he had a lung lesion, I certainly would have turned first to the TTF1. If the TTF1 had been positive, that would probably settle it right there. I would say, well, I think I was wrong. If I still had to consider kidney, at that point, I would say yes, let's do a mucicarmine.

Q. All right, then. You were doing a mucicarmine to rule in

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or rule out lung versus --

A. Well, actually to rule out kidney.
Q. All right. Would it have been helpful?
A. At that point, yes.
Q. Yes, sir.

Again, that would be something that would have been

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routinely done here in your practice, right?
A. Certainly.
Q. Now, it wasn't just Doctor Hammar who had an opportunity to stain this material, correct?
A. That's correct.
Q. Had you wanted the blocks of tissue so that you could take the microtome, as you described, and cut a thin portion -- although I understand that you don't do the staining with your own hands -- you could have asked that it be done?
A. Yes, I haven't done it with my own hands in many decades, but I could have it done.
Q. Just to make it clear. The doctor has the laboratory do it?
A. Most of the time. Mucicarmine stains, that's done by technical people. If you are dealing with something really esoteric, that's different. I do it with my own hands.
Q. Otherwise, you could have had it sent out and someone would have done it for you?
A. Yes, sir.

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Q. You could have taken your stain, your work and compared it to the one that you are talking about to see if it matched, correct?
A. With mine?
Q. Pardon me?
A. With a controlled slide?
Q. Well, your controlled slide, sure.
A. Well, there would be no point -- excuse me, I can't see any point in comparing a new control with this because this is the standard by which we are judging other things. I would say this -- and perhaps I am being a little obtuse and I apologize if I do not understand the question -- I will say this: If I sent it out to Doctor Nadji's laboratory or Doctor Civantos to get a mucicarmine stain, then I would require them -- which they would do anyway -- to send me a new control. I would compare that control not with this, but I would compare that control with these tissues from Mr. Allen.
Q. Now, I'm afraid you have lost me.
I thought that in order to be valid anywhere in the world, Berlin, Tokyo, anywhere else, it had to come back and look just like this. Isn't that what you said, this is the world standard?
A. I didn't say anything inconsistent with that, sir. What I said is, if I could repeat my answer. What I said is, that is the world standard. If I sent it out, there is no point in my

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comparing another good control with that. They're the same as plain as day.
What I would do is demand -- I wouldn't have to demand because they follow mandated procedures. I would look at their control and compare it with the mucicarmine stain on the tissues from Mr. Allen's body. I have to do that because I don't know, looking simply at the tissues in his body, whether the stain was properly done or not. I have to see the control done in their laboratory at the same time they stain his. I am not going to look at my wife's stain. I am going to look at the stain that was done by Doctor Nadji or Civantos, or whoever did it for me.
Q. So let me see if I understand this now. Listen very carefully, please. If you decided as part of this case that, you know what, I have a twenty-year relationship with the people back at Jackson, I was a professor there, I know a lot of them by first name, Frank, for example, who you mentioned --

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A. I am sorry. Don't mean to be too familiar.
Q. It doesn't matter.
-- and you wanted to get to the bottom of this, you could have, you told us, requested the paraffin blocks, had the very thin slicing done, and sent it down to Jackson where the work could have been done?
A. Sure.
Q. But you would want to have -- you would want to have, when

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they send you back the slides, their stains; you would want their control?
A. I must have it.
Q. That must mean that their control could possibly look different than --
A. No, sir, you are missing the point.
Q. I must be.
A. Yes, unless they move up to the accepted standard when they stay in the control, they have failed. I am going to score them pass or fail. They have to provide me with a control which is acceptable. The picture to your right is acceptable. That is the standard that applies around the world. The reason I need their control is to make sure they did it right. That's what is absent here when I looked at Mr. Allen's slides, the control was unavailable.
Q. Now, Doctor Hammar's control slide, did you request it?
A. No. I may have asked for it. I think I asked if it was available, but my memory might not be right on there.
MR. REILLY: Objection, Your Honor. I asked for it.
THE COURT: Just a moment now. Don't be volunteering unless you want to be sworn and cross-examined.
You will disregard that, ladies and gentlemen. Go ahead.
BY MR. GROSSMAN:
Q. But there is no question that you recognized the value of

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mucicarmine staining in demonstrating a primary lung cancer; no question about that?
A. There is a question about that. I follow the generally accepted practice as stated by the author you mentioned a while ago, Corrin and Colby and Travis, that we do not use special stains to make a diagnosis of the cell type of lung cancer. That's in the AIP Fascicle edited by that group of people, and it's also in the World Health Organization Fascicle. Pathologists do not use histochemistry to establish the cell type. We do that basically with the H & E, and then we seek indophenol case's support or the negation of our original diagnosis. You have a sophisticated use of those tests. The tests do not establish the diagnosis.
Q. Yes. What foot did this specimen come from?
A. I believe it was -- well, I am not sure. I don't really recall.
Q. Well, in this particular case, where at least you believe there was a question is it lung or is it kidney, based upon some memo that you showed us, certainly this would have been an appropriate case to have this staining done if in fact there was a question as between renal versus lung, correct?
A. I believe I said that, but perhaps, in relation to a specific question. But, certainly, I would agree with that. What I would like to --
Q. Along those lines?

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MR. REILLY: Excuse me. If he could finish his answer.

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BY MR. GROSSMAN:
Q. I am sorry. I didn't hear you. Say whatever you would like.
A. I beg your pardon, sir. I would like to add that Doctor Nadji and others who have looked at this case were looking at it in terms of the differential diagnosis of kidney versus lung. I didn't look at it that way.
I included the differential diagnosis in my thought processes, but if you read the notes that were provided to your law firm, you will see that in addition to considering those two possible sources of the tumor, I mentioned two or three others which I think have to be considered here. We cannot restrict our attention simply is this from the lung or is this from the kidney because it could have been from other sites.
Q. Now you think other sites might have caused it?
A. Not now, sir. Those are in the notes provided by Mr. Yaffa.
Q. I have those notes. We will get to them in a moment.
But you answered the question about the need for doing this.
Who is Doctor Temple?
A. Who?
Q. Who.

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A. Who?
Q. Who.
THE WITNESS: Abbott and Costello here.
THE COURT: Sounded like we were in the Appalachian Forest at 10:00 at night with some owls around. Who, who, who.
BY MR. GROSSMAN:
Q. I am sorry.
Who is Doctor Temple?
A. Doctor Temple, I believe, is now director of the section of orthopedic oncology at University of Miami. He is also associated with the Sylvester Cancer Institute.
Q. Did he have anything to do with this case?
A. Yes, sir, I believe he was the person who biopsied it.
Q. Doctor Temple is a full professor of orthopaedic oncology, did you know that?
A. No, sir, as a matter of fact, let me add that I never met Doctor Temple.
Q. So you do not know him at all?
A. No, I do not know him personally.
Q. You wouldn't know that he has a secondary appointment in the department of pathology?
A. Yes, I do know.
Q. How do you know that?
A. Because I read it in his trial testimony, a copy of which was supplied to me last week.

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Q. You actually got a copy of the testimony that Doctor Temple gave who is sitting in the same witness stand as yours?
A. Yes, sir, I did.
Q. You also saw that he was the head of the University of Miami Tissue Bank?
A. Yes.
Q. You also saw what his findings were at the time of surgery, did you not?
A. I did.
Q. Did you also have an opportunity to see what Doctor Temple's opinion was as to whether or not this was lung cancer or not?
A. Yes, sir, I did.

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Q. You talked about the naked eye. The first thing you said that a pathologist would do when he gets the tissue out is he would look at it; he would look at it, even before the slicing into small bits for analysis, even before the staining takes place, you would want to look at it, correct?
A. With a typical case, yes.
Q. Doctor Temple looked at the this lesion, this tumor, when it was in the foot of Mr. Allen; did he not?
A. Yes, sir, it was he who curetted it out of the bone.
Q. Do you recall, either from looking at the medical records which you have been asked to look at and say that you have read, how much blood loss there was?

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A. Practically none.
Q. So little blood loss that a tourniquet wasn't used?
A. Well, you wouldn't expect otherwise. Bearing in mind that this is a very small lesion and what Doctor Temple did was simply to curet the bone after making an incision in the skin. It's not unusual for there to be practically no blood loss.
Q. Doctor Temple said, I believe, you recall, or do you recall how minimal the bleeding was?
A. He wasn't referring, as I understood his testimony, to the overall procedure, but he was referring specifically to the tissue composing the tumor.
Q. Yes, that's right.
Do you recall him saying that he didn't have to do anything except simply apply pressure to stop the bleeding?
A. Correct.
Q. Do you know how much surgery Doctor Tom Temple has done, not just here at Jackson, but at Walter Reid and in the Army before that, on bone tissue and bone cancer?
A. I only have a vague idea.
Q. Do you think he has had a lot of experience?
A. Unquestionably.
Q. Do you think that this person, this surgeon, this surgeon of Bob Allen's, had an opportunity to look at that which he was exercising while he was doing the work?
A. Yes.

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Q. You have read his testimony about that prior to coming in here today?
A. Yes, sir, I did.
Q. I could be wrong, but did counsel for Philip Morris ask you about anything of Doctor Temple's testimony or was I the first person to bring it up?
A. I'm sorry. I don't understand the question.
Q. Were you asked any questions by counsel for Philip Morris, questions about demeanor?
MR. REILLY: I object.
THE WITNESS: No. In fact, there was no communication at all. I was sent the trial testimony. I read it. I did not comment on it.
BY MR. GROSSMAN:
Q. You were sent Doctor Temple's testimony. He is the surgeon. He has testified before the jury. Was there a cover letter?
A. Well, if there's a cover letter, it was his usual one sentence, "Here's the copy of the trial testimony for you to read, if you wish."
Q. The idea was for you to do what, read it?
A. Yes, sir.
Q. That's what you did?
A. That's what I did.

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Q. For the time that you spent you billed?
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A. A hundred fifty dollars an hour.
Q. And for the time you are testifying it's five hundred dollars an hour?
A. Yes, sir.
Q. People go to the trouble of mailing you this and you go to the trouble of reading it, you are saying that you never commented at all about Doctor Temple?
A. Not one syllable.
Q. Not one syllable?
A. All they did was prepare me to talk with you this morning.
Q. I am just curious, were other portions of this trial transcript sent to you?
A. Yes, and the same rules applied. I didn't discuss anything whatsoever with the attorneys that sent it to me.
Q. What rule is that? What rule are you talking about, the same rule applies?
A. Well, as a rule, if I am sent trial testimony, I read it, I try to assimilate it, understand it so I can sit here and talk intelligently about the problem. I don't need to talk with the attorneys. The opinions I am expressing are my own. I have no need to assist them in their legal business, and I don't need their input.
Q. So you are sent these transcripts, but you are not sure why?
A. For me to read, I believe, I assume.
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MR. REILLY: Objection, Your Honor. What is the relevance of this?
THE COURT: Let's see where it goes. Go ahead.
BY MR. GROSSMAN:
Q. Along those lines, did you also get the sworn testimony in court of Doctor Nadji, your former student?
A. I did indeed, yes.
Q. You read Doctor Nadji's opinions?
A. Yes. I would not like to characterize Doctor Nadji precisely as my former student. I had a role in his education, but his basic training had already been accomplished by the time he and I began to interact in his third and fourth year.
Q. He was already well along the way?
A. Oh, yes, he was in his senior status.
Q. Okay, fine. In any event, is the same true, that there was no comment given about Doctor Nadji?
A. I am sorry?
Q. You made no comment to counsel about Doctor Nadji, this rule you are talking about?
A. No, there is an exception there. Thank you for a reminder of that. As a matter of fact, I believe it was on a Saturday we were informally talking about something.
Q. Which Saturday was that?
A. This past Saturday.
Q. How long have you been in South Florida?
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A. Well, I got in late on Friday.
Q. So you were here all weekend?
A. Yes.
Q. Set the stage. Who is at the informal discussion, who are you talking about?
A. In the offices of Shook, Hardy & Bacon.
Q. That's these folks, these lawyers?
MR. REILLY: Yes, sir, that's us.
THE WITNESS: You referred to them as Philip Morris.

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Honestly, I don't even know the tobacco firm. I know the defense, Philip Morris, but I don't know anything more about it than that. It could be a different tobacco firm, as far as I am concerned.
BY MR. GROSSMAN:
Q. When we asked you to give us a list of the cases, you testified you've always told us the name of the tobacco company. You've always given us the style of the case, including the name of the tobacco company.
A. I look it up. It's very simple. Listen, I am not an attorney, and I'm not even interested in the legal process. What I do if somebody asks me to update my CV, I go scrounging around for pieces of paper and I update it. I don't keep in mind who represents whom. That is just not my business. I am in a profession as a consultant. That has nothing to do with the legal process directly. But I am sorry. I interrupted

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you. I apologize.
Q. That's okay. I probably asked for it. Meaning, I probably asked you just a different question. Not your fault at all.
But I do want to come back to the Saturday meeting, whether you know the names or you don't know who you represent or whatever it might be. I wasn't there. My partners weren't there.
A. I would be very happy to tell you who is there.
Q. Sure.
A. Counsel Mr. Reilly and also Mr. Barr were in the room, and we talked about a number of things informally. Doctor Nadji came up in a rather casual way.
Q. Casual?
A. I may have said something like, "Well, how did Nadji come across?" You know, he's friend of mine.
Q. How did Nadji come across, you mean to the jury?
A. No, I don't know anything about come across to the jury. I was asking the opinion of somebody who had been in the room. Namely, Mr. Reilly, and I just wanted to know how Nadji was doing. As a matter of fact, we are old friends.
Q. I'm sorry, did you want to know how Nadji was doing in life or how did Nadji do when he sat in that seat, looked at the jury, took the same oath, and gave his opinions in this case?
A. Sir, I have already said that I read his testimony, so I was familiar with that. I think I said something to the effect

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to one of the attorneys, "Well, how did Nadji do?" You know, wondering what his impression of the overall experience was. That's about it.
MR. GROSSMAN: Your Honor, at any time you would like to take a break.
THE COURT: This is as good a time as any.
Ladies and gentlemen, it is now 12:36 approximately. Why don't we say 2:00 this afternoon. Don't discuss the case with anyone or permit anyone to talk to you about the case. If there should be anything in the radio, television or the newspaper, don't read or watch or listen to it.
Marshal, will you see they get uninterrupted to the elevator. 2:00.
The witness is instructed not to have any conversation with the lawyers or paralegals or anybody during the recess since you're in the middle of your testimony..
[Morning proceedings concluded at 12:37 p.m.]

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C E R T I F I C A T E

I hereby certify that the foregoing is an accurate transcription of proceedings in the above-entitled matter.

_____ _____

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